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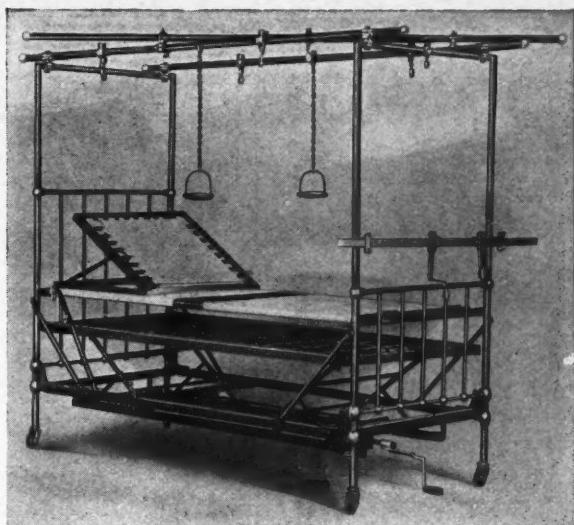
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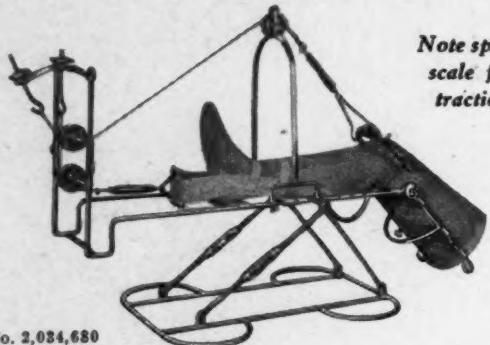
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and laboratory experts, it is said, analyze the raw water you use and advise on correct chemicals; they suggest proper dosages of chemicals and adequate feeding devices. Finally, since composition of water varies and conditions of operation change from day to day, Permutit supplies a simple test kit for checking. Reports of daily tests are sent to the company's laboratories and experts' recommendations are returned to the hospital—this is in addition to services always available from a field staff.

Uniforms Trimly Tailored—Obviously, a nurse's pride and joy is her spotless, pleasing uniform. Helpfully, Angelica Jacket Co., 1405 Olive Street, St. Louis, proffers a series of pictures in a folder just released, showing apparel in professional yet "humanized" version. Sailor collared, form fitting, "Princess" modeled, even Hollywood styled, these uniforms seem designed to suit the most fastidious of purchasers. And, just to finish off the apparel problem, this company also offers the latest styles to surgeons, interns or hospital patients in another new circular entitled "1936 Professional Apparel for Office and Hospital."

World-Widely Used Is Tea—"But," asks Tea Market Expansion Bureau in a recently issued folder, "does everyone know how to make it? To some the idea of brewing a pot of tea a full five minutes may seem something new. However, to experts the idea is a set, inviolable rule, never to be broken. It takes that time to dilate or expand the tea leaves fully and bring out the natural oils and juices." From 82 Beaver Street, New York City, the Bureau will send interested readers a digest of medical opinions on tea as a beneficial beverage, directions for making and serving, details of historic background and of present methods of production.

Small Quantity for Much Cleaning—Glassware gleams filmlessly, one hears, and windows shine streaklessly when treated to small dosages of Oakite cleaning materials. Oakite Products, Inc., 22 Thames Street, New York City, asserts in a folder just received that small amounts of their compounds suffice for large jobs, since each grain is pure cleaner, with no filler or inert matter. This company offers to send those interested, "money-saving" data on these six subjects: dishwashing; general kitchen cleaning; painted wall and woodwork cleaning; laundry detergents; floor washing, and paint stripping from metal furniture prior to refinishing.

Mats, Safe and Sanitary—Lately from the press is a booklet by American Mat Corporation, Toledo, Ohio, makers of safety matting designed to prevent people's stumbling and slipping on floors or stairways. Dirt trapped at lobby entrances, in addition to the nontrip feature, is the proud boast of Ezy-rug. This, of link construction and with spaced corrugated ridges on top of links, is said to scrape dirt from shoes of incoming hospital visitors. Another matting is the Amatco, a runner reported easy to clean because of its wide-ribbed corrugations. A third is the Counter-tred, a nonslip safety mat designed for dishwashing rooms, laundries or other slippery floor areas. Nontrip beveled edgings are used when needed on ends or edges of these matting products.

So You're Going to Plan a Laundry—Sleuthing about for data on laundry planning, we discover sheets new, at least to us. American Laundry Machinery Co., Cincinnati, supplies "Pencil Points Data Sheets," including "Planning the Hospital Laundry" and another sheet, a general analysis of laundry planning. Ten square feet of laundry area per patient bed is a practical minimum to be allowed, they advise, while 14 square feet of laundry per patient bed may be taken as a practical maximum.

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AUG 4 1936



the
**MODERN
HOSPITAL**

VOLUME 47

AUGUST 1936

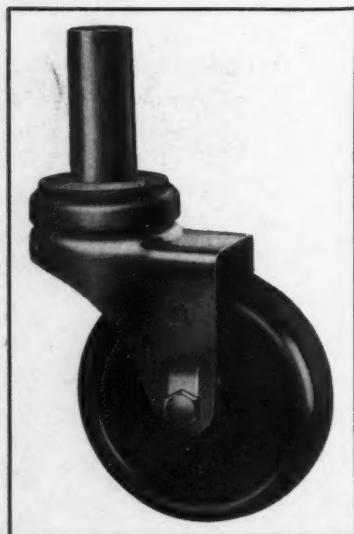
NUMBER 2

STICKLEY-BUILT FURNITURE FOR HOSPITALS AND INSTITUTIONS



Like many another enterprise, hospitals build reputation through satisfied patrons. The average person instinctively abhors "going to the hospital," an environment suggestive of operating rooms, white beds and stark cleanliness.

Stickley Brothers Corporation has done much to "Humanize the Hospital." The able executives of that organization in co-operation with forward looking hospital administrators, have done much to sell the value of cheerful, homelike surroundings in hospitals thereby creating many more "satisfied" patients. Stickley-built furniture is not alone built to endure the severe service required of hospital furniture—it is also built attractively so as to create a most favorable impression with the patient as well as their relatives and friends. That Stickley-built beds are now in daily use in over five hundred hospitals, nurses' homes and institutions attests to the success of their humanizing idea.



The Jarvis & Jarvis caster illustrated on the bed above is No. 3195-PON. This is one of the many casters we make that are adaptable for hospital furniture.

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For August, 1936

Just in Passing—

COVER PAGE—Miller Memorial Hospital, Duluth, Minn. Erickson & Company, Duluth, Architects. Ellerbe Company, St. Paul, Associate Architects.

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NEXT month hospital forces from all over the country convene in Cleveland. In annual convention assembled the members of the American Hospital Association and related bodies will argue, discuss, expound, gossip, nominate, elect and resolve. In exhibit halls, lobbies and hotel rooms they will meet and greet. Some administrators, however, will steal away from the convention to pay visits to Cleveland's outstanding hospitals. There they will see many new pieces of equipment, well planned departments and interesting facilities for carrying on all of the hospital's multifarious activities.

So that those who wish to look and learn may do so with the greatest economy of time and taxis, The MODERN HOSPITAL will publish next month a Baedeker to Cleveland hospitals. Prepared by one of the city's ablest administrators, it will tell you quickly just what things are most important to see in each of the Cleveland institutions. With it you can make your tour far more profitably than could be done by any hit-and-miss system.

OUT OF the east comes these days much talk about "health centers." Just what is a health center? What does it do? Who maintains it? Who uses it? Why has the federal government been granting money to erect such centers? What relation do they have to hospitals?

Dr. Charles F. Wilinsky, who combines in one person the administrative ability of a hospital director and the vision of a health officer, will give in the September issue the answers to these questions. And Doctor Wilinsky

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should know because Boston is one of the most aggressive cities in the United States in providing health centers.

A SPEECH clinic in a hospital! But we all speak all right now.—No, the speech clinic isn't for you. It is for the children who don't speak easily and understandably. If someone doesn't help them overcome their handicap, the inferiority complex will get them. And wouldn't that just ruin their lives. But the children in Columbus, Ohio, don't have to worry. They can go to the Children's Hospital and get their difficulties all ironed out. Next month the clinic director will tell what and why.

"ADMINISTRATIVE Case Histories" is sort of a mouthful, isn't it? Yes, perhaps, but it is far more than that. It is a new kind of article starting next month that will compel your interest from first to last. It is a series of case histories of actual problems faced by hospital administrators and a review of what they did. Personally we think they are better than detective stories. Furthermore you may have just the same problem to solve yourself, either now or next week.

"THE spirit of the modern mental hospital must come out of the gate and into the community interpreting to the community the change that has been wrought in our conception of mental disease and the method of cure. Without this interpretation, much ground will be lost with the inevitable reduction in funds available for the program." Thus does Dr. Ellen C. Potter of the department of institutions and agencies of New Jersey set forth in next month's article the "why" of a public relations program for mental hospitals.

THREE are several distinct needs in postgraduate education of nurses. Any hospital which undertakes such education should first analyze carefully just which of these needs it proposes to satisfy and then should tailor its educational program to fit those particular needs. Shotgun education methods

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ought to be as obsolete as shotgun prescribing. Marion J. Faber of the Cook County School of Nursing will present next month a logical analysis of these needs. Both nurses and nurse educators will find her article of value.

FLASHES FROM THIS ISSUE:

"All the world over noise in hospitals is condemned and it is astonishing that so little provision is made for guarding against this evil." *Page 45.*

"Hospital trustees and administrators, as well as those responsible for raising community funds or other agencies subsidizing hospitals, face the fact that some more certain way of providing hospital budgets must be found." *Page 47.*

"It is said that thirty years ago there was one nurse for every thirty doctors and that today we have two nurses for every one doctor." *Page 51.*

"Another unquestioned obligation of an institution operating under a not for profit charter is that of exercising scrupulous care that no one profits abnormally by the operation of the institution." *Page 59.*

"A reassuring smile from the attendant polishing the handle of the front door will accomplish wonders in establishing it in the visitor's mind as a friendly doorway." *Page 63.*

"Free work is dependent on the type of hospital practice and must be worked out to suit local exigencies." *Page 75.*

"Dishes spotted with food may yet be sterile as a result of heat or chemicals and dishes that look clean may have a high bacterial count." *Page 82.*

"During the past decade hospitals have been singled out as a target of attack for an alleged exploitation of young American womanhood for cheap labor." *Page 51.*

"Important things—work schedules! They are to an institution what subconscious actions are to an individual." *Page 56.*

"While it is seldom that epidemics have been spread with improperly washed dishes . . . the hospital cannot afford to take unnecessary risks." *Page 86.*

"With all that is known about the modern hospital and all that is spent for its planning, no detail is so trivial that it may be neglected." *Page 68.*

THE MODERN HOSPITAL

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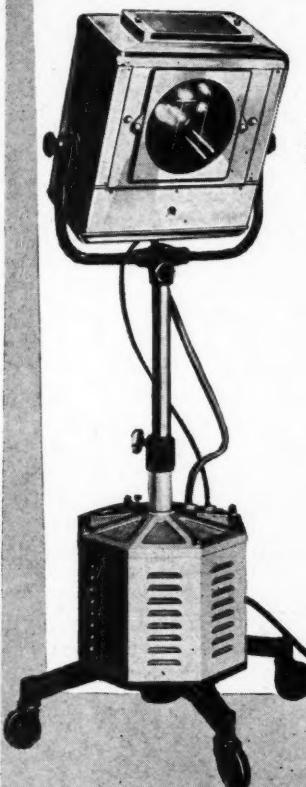
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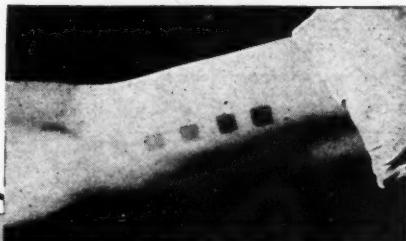
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The Hospital Barometer

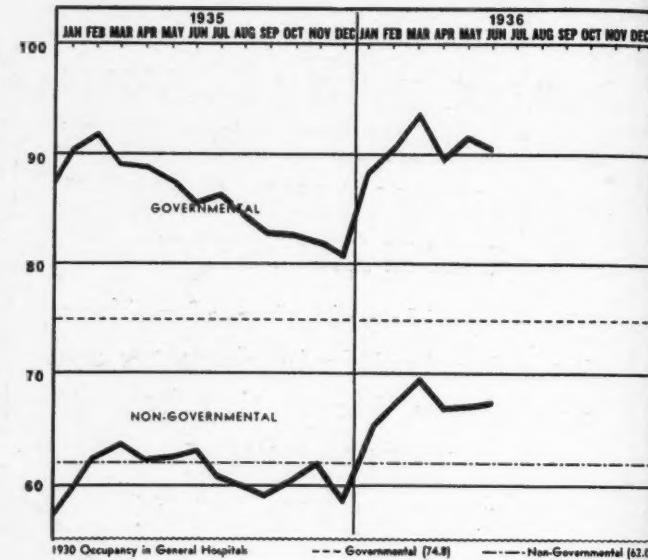
In spite of drought and political conventions, the occupancy in nongovernment general hospitals in June continued at a high level, maintaining an advance of over four points above the figures for June, 1935. The increase over last year was fairly general in all the reporting cities but was especially marked in St. Paul, Chicago and Cleveland.

Government general hospitals continued at a high rate of occupancy. The figures for New Orleans are very high because of unusual crowding in one hospital. If they are omitted the average drops to 79.7, which compares with 77.7 for June, 1935. The steps taken by Commissioner Goldwater to reduce overcrowding are reflected in the June figures for New York City.

New hospital building projects continue to be reported in large numbers. The total for the period from June 22 to July 22 was 50 projects of which 42 reported costs of \$11,615,200. Except for June, this is the largest monthly total reported in the last three and one-half years. Of these projects, 13 were new hospitals costing \$6,935,000; 32 were additions of which 24 reported costs totaling \$4,270,700; one alteration is to cost \$75,000, and four nurses' homes will come to \$334,000.

Industrial activity advanced for the fourth consecutive month in June and was maintained at a relatively high level during the first half of July, according to the monthly business survey of the National Industrial Conference Board. During June expansion took place in residential and public works construction and in the bituminous coal, zinc, machine tool, electric power and cotton textile industries. Less-than-seasonal declines occurred in automobile, steel and petroleum output. Indexes of trade and distribution continued to reflect improvement.

Wholesale prices as reflected in the index of the *New York Journal of Commerce* advanced somewhat between June 23 and July 14 but then dropped slightly. Grain



prices, however, advanced markedly, the index going from 80.7 on June 23 to 92.9 on July 21. In spite of this, however, the index for wholesale prices of food in general showed a decline, dropping from 81.5 to 79.0 during the period.

Textile prices showed an advance from 66.0 to 68.2 and the cost of building materials moved up slightly. Fuel dropped in price a little. The price index for drugs and fine chemicals of the *Oil, Paint and Drug Reporter*, after a rapid drop during the preceding month, remained practically unchanged during the period under review.

The cost of living of industrial wage earners continued to rise, advancing 1.7 per cent during June owing to increases in food costs and rents.

OCCUPANCY FIGURES OF HOSPITALS IN VARIOUS STATES AND CITIES

| Type and Place | Census Data on Reporting Hospitals ¹ | | 1935 | | | | | | | 1936 | | | | | |
|----------------------------|---|-------------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|--------------|-------------|-------------|-------------|--------------|--------------|
| | Hospitals | Beds ² | June | July | Aug. | Sept. | Oct. | Nov. | Dec. | Jan. | Feb. | March | April | May | June |
| Nongovernmental | | | | | | | | | | | | | | | |
| New York City ³ | 68 | 15,194 | 72.0 | 66.0 | 62.0 | 62.0 | 67.0 | 69.0 | 66.0 | 71.0 | 75.0 | 77.0 | 75.0 | 75.0* | 75.0* |
| New Jersey | 54 | 9,972 | 64.0 | 62.0 | 60.0 | 60.0 | 62.0 | 63.0 | 62.0 | 66.0 | 70.0 | 69.0 | 66.0 | 66.0 | 66.0* |
| Washington, D. C. | 9 | 1,792 | 70.6 | 68.2 | 62.0 | 63.9 | 68.3 | 68.3 | 63.0 | 70.8 | 77.5 | 78.4 | 71.2 | 70.9 | 73.2 |
| N. and S. Carolina | 103 | 6,328 | 66.8 | 65.7 | 66.3 | 65.7 | 64.4 | 63.3 | 59.1 | 63.9 | 67.1 | 68.7 | 64.9 | 65.0 | 67.3 |
| New Orleans | 7 | 1,146 | 58.3 | 57.1 | 58.2 | 55.1 | 53.3 | 55.8 | 50.8 | 58.3 | 56.9 | 62.5 | 58.2 | 61.2* | 63.0 |
| San Francisco | 16 | 3,098 | 67.4 | 62.4 | 63.9 | 63.9 | 66.7 | 70.2 | 65.2 | 71.9 | 75.6 | 71.7 | 72.3 | 70.6 | 70.6* |
| St. Paul | 7 | 838 | 51.7 | 46.4 | 49.1 | 48.5 | 46.6 | 50.7 | 49.0 | 56.7 | 57.2 | 61.1 | 58.8 | 57.6 | 58.2 |
| Chicago | 22 | 4,297 | 54.7 | 54.5 | 53.8 | 53.8 | 54.7 | 54.9 | 52.8 | 56.5 | 61.4 | 63.9 | 63.1 | 64.6 | 64.8 |
| Cleveland | 8 | 1,201 | 63.4 | 63.2 | 63.4 | 58.5 | 61.7 | 62.3 | 60.6 | 66.5 | 68.3 | 72.2 | 72.9 | 73.6 | 70.7 |
| Total⁴ | 294 | 43,666 | 63.2 | 60.6 | 59.9 | 59.0 | 60.5 | 61.9 | 58.7 | 64.6 | 67.3 | 69.3 | 66.9 | 67.1* | 67.6* |
| Governmental | | | | | | | | | | | | | | | |
| New York City | 17 | 12,042 | 100.4 | 103.6 | 93.2 | 91.7 | 85.8 | 86.5 | 87.3 | 95.1 | 100.2 | 98.2 | 95.8 | 100.4 | 90.3 |
| New Jersey | 5 | 2,122 | 77.0 | 79.0 | 79.0 | 76.0 | 84.0 | 78.0 | 76.0 | 80.0 | 84.0 | 84.0 | 81.0 | 84.0 | 84.0* |
| Washington, D. C. | 2 | 1,596 | 67.4 | 68.4 | 69.5 | 62.9 | 60.4 | 60.4 | 62.9 | 71.4 | 73.3 | 68.9 | 66.7 | 62.9 | 65.5 |
| N. and S. Carolina | 13 | 1,358 | 68.1 | 68.7 | 72.3 | 68.0 | 66.9 | 65.4 | 63.8 | 71.4 | 73.8 | 75.8 | 71.8 | 73.0 | 75.2 |
| New Orleans | 2 | 2,227 | 138.8 | 149.0 | 143.1 | 140.9 | 138.5 | 137.4 | 127.8 | 130.0* | 141.3 | 169.8 | 146.2 | 164.2 | 168.2 |
| San Francisco | 3 | 2,255 | 72.3 | 72.0 | 71.3 | 79.5 | 76.8 | 79.1 | 81.1 | 83.5 | 83.4 | 79.2 | 81.2 | 80.9 | 80.9* |
| St. Paul | 1 | 850 | 74.5 | 67.3 | 63.4 | 61.5 | 65.0 | 68.6 | 66.6 | 94.9 | 85.4 | 84.5 | 82.7 | 80.0 | 77.9 |
| Chicago | 2 | 3,698 | 84.5 | 83.5 | 80.5 | 80.4 | 81.7 | 80.2 | 79.5 | 83.3 | 86.0 | 87.9 | 87.2 | 85.2 | 84.3 |
| Total⁴ | 45 | 26,148 | 85.4 | 86.4 | 84.0 | 82.6 | 82.4 | 81.9 | 80.6 | 88.7* | 90.8 | 93.5 | 89.6 | 91.3 | 90.7* |

¹Insofar as possible hospitals for tuberculous and mental patients are excluded as well as hospital departments of jails and other institutions. The census data are for the most recent month. ²Including bassinets, in most instances. ³Includes only general hospitals. ⁴The occupancy totals are unweighted averages. These averages are used in the chart above. *Preliminary report.

THE EASTERN STEAMSHIP
COMPANY GETS

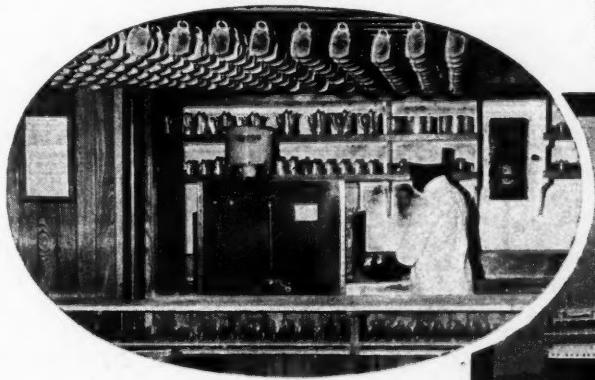
Clean dishes



Don't apologize—calgonize!
calgonite

CALGON, INC., PITTSBURGH, PA.

Adv. No. 39-D

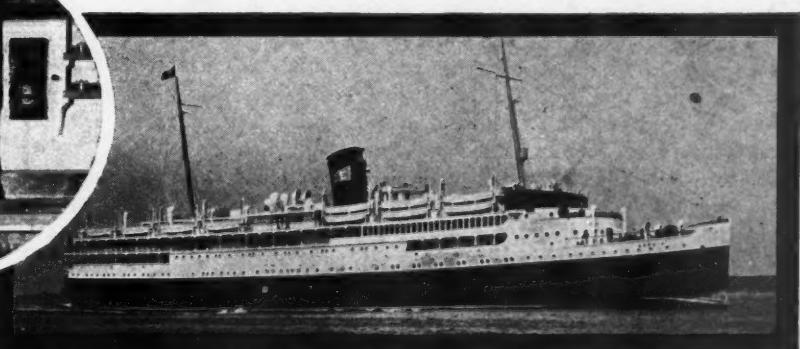


The Acadia and Saint John, Eastern Steamship Company liners plying between New York, Boston and Nova Scotia, have created a sensation in marine circles. They combine the best in modern marine engineering, decorative art and traveling comfort. Each, built in American yards, has six decks, is over 400 feet long, and has a speed of 22 knots. In winter, these boats ply between New York and Boston; in summer they cruise to Nova Scotia or on special charter cruises.

From recreation quarters to dining room and galleys, appointments are the finest. In the dining room, heart of any ship, one sees the care put into food quality and service, silver, dishes, and napery.

It is not surprising that the problem of clean sparkling dishes led the management straight to Calgonite—and has kept the steamers on Calgonite ever since, with beautiful results.

These same results you can have. Your kitchens may not be on any passenger liner, but your patrons—or your patients—are just as deserving of having the food, which you plan and prepare with so much pride, served on dishes that are scientifically clean.



The Editor Talks It Over

• What do you do with the many boxes that come to the hospital filled with flowers for the patients? The answer to this question would probably be, in most cases, "Why, we put them in the refuse can, of course, of what use are they?" Has it ever occurred to you that nearly everything might have some further use, or even an exchange or purchasing value? Well, so it is with flower boxes. In one hospital an arrangement was made with a local florist's shop whereby empty boxes were picked up on call. Not only boxes from the florist's own shop are saved, but all good boxes, an address sticker being placed over the name of the former box owner. In exchange, vases of good type and in a sufficient number are received, so that none have been purchased in the past four years. Thus an entirely useless article becomes converted into a really necessary one with no financial outlay or labor involved.

• The tinkle of ice in the glass no matter what constitutes the other ingredients is suggestive of cool verandas, rippling lakes and wide stretches on a green golf course. The hospital superintendent if he is to render the greatest aid to his institutional family should not deny himself the rest and recreation which a summer vacation brings.

Before packing his bags and turning his car toward the forest and lake or seashore, he should not forget the suffering and discomfort which long humid nights and blisteringly hot days bring to those who are ill. Can there be any more uncomfortable experience than to wear a body cast during the summer months? What of those who must bear the burning torments of high fever during tropical August?

To be humane, a hospital must provide all mechanical devices that make summer bearable to the sick. Ceiling fans in hot wards, air conditioned operating rooms, cooling drinks as surprises when the temperature is the highest and even the plebeian palm leaf if provided in ample numbers will be welcome additions to the hospital's hot weather equipment. The cool nights and pleasure laden days

of the superintendent's vacation will be made all the more delightful by the knowledge that his ailing friends at home have been protected against summer discomforts.

• Insulin protamine is an interesting remedy. While possessing the carbohydrate burning activity of insulin, it has the added advantage of persisting in its effects over a longer period. This being the case, the patient is spared the pain and inconvenience of so many hypodermic injections. If the diabetic could be supplied with insulin to be orally ingested a real contribution to medicine would be made.

• In the July *American Mercury* Henry Morton Robinson discusses under the title "The Newest American Racket" the growing tendency for patients to sue physicians for real or imagined wrongs. Herein is stated that in 1935 six times as many malpractice suits were recorded as in 1921. He hazards the prophecy that one out of twenty doctors practicing in the United States will be sued in 1936. Surely, says this writer, this unusual increase in malpractice litigation is not the result of poorer medical service. No doubt as long as shyster doctors and lawyers are to be found the greedy and unprincipled will endeavor to profit at the expense of the ethical physician.

Attention should be called to the famous decision of Chief Justice Taft who declared that a physician is not a warrantor of cures. Hospital people can only affirm and at the same time express surprise at the feebleness of the following statement, "Nowadays many surgeons will not make an incision unless permission has first been received from the patient in handwriting." It cannot be too strongly stressed that no hospital should permit an operation to be performed without a definite, carefully worded and legally binding permission for operation having been first signed by the patient or his responsible relatives. This interesting article holds out encouragement to the ethical doctor in the statement that only one out of ten of the suits will succeed.

• At the two recently held national political conventions an interesting device was employed to measure intensity of applause following more or less interesting and effective addresses. It would be a splendid addition to the equipment of hospitals if someone could devise a method of measuring and later obviating intra and extra institutional noise.

The hospital director arguing before the public as a jury would certainly be acclaimed as just and fair when he insisted that braying automobile horns and crashing and squeaking street cars in the vicinity of a hospital should be declared a public nuisance. London's law forbidding the use of automobile horns is splendid. In this country courtesy is almost synonymous with auto horn blowing and still in some localities the public honestly endeavors to protect the hospital's sick.

In one city a prominent commercial organization retailing milk has provided its horses with rubber shoes to obviate the 5 a.m. "clop-clop" which arouses the sleeping suburbanite to the knowledge that the milkman has come. A local drive to bring about quiet in hospital zones is to be highly commended.

• Do you have standardized equipment of electric light bulbs in your hospital rooms? In an Eastern hotel a recent study on this point discovered a heterogeneous equipment of bulbs in guest rooms which when reduced to a standard of 25 and 40-watt size saved the institution nearly one thousand dollars a year in electric bills.

• Abraham Lincoln defined politicians as "a set of men who have interests aside from the interest of the people and who, to say the best of them are, taken as a class, at least one long step removed from common honesty." These interests which are aside from the interests of the people may be displayed by the ward, county, state or federal politician. They may even be typically manifested by the staff self-seeker. The superintendent of the hospital should beware of those who display a desire to satisfy aims which are foreign to the welfare of the people as a whole.

Looking Forward

Hospital Labor Unions

THE history of industrial nations indicates that in general labor is remunerated according to its strength. Nations differ, of course, in their natural resources, their technical advancement and their opportunities for trade. These differences put limits on the whole industrial system of each nation. Within these limits, however, there are opportunities for considerable variation depending upon the relative strength of the employers and the employees.

By and large employee bargaining power rests upon organization. Organized labor, when wisely directed, can and does obtain better wages and working conditions than unorganized labor. When labor is not organized, enlightened employers are handicapped by competition from those who cut wages to the lowest possible point.

Under a capitalistic system it is practically inevitable that the lower paid workers will seek to advance their wages and working conditions through collective bargaining. Yet one experiences a distinct shock on hearing that a union of hospital and institutional workers has been formed in San Francisco and that another union of professional hospital workers is active in New York City. The purpose and activity of the non-profit hospital is so permeated with public interest, its basic philosophy is so far removed from that of industry! The hospital's real balance sheet is not expressed in terms of financial profit or loss but in terms of lives lost or saved, injuries and illnesses cured or unimproved and education provided on a low or high level.

In this balance sheet every hospital worker participates to some degree. The office clerk whose efficient, courteous treatment reassures a frightened patient has added something to the credit side, while the employee who misuses a machine and necessitates its early replacement cuts down on the hospital's service. One additional free patient might have been accepted had he been more careful.

The newly formed San Francisco union states that "all institutional help, other than skilled or professional workers, shall be hired only through the office of the Hospital and Institutional Workers Union, Local 19816" as long as the union is

able to furnish necessary employees. It demands an eight-hour day, a six-day week and minimum wages of \$75 a month and maintenance for porters, janitorial workers, male and female orderlies, kitchen helpers and other miscellaneous workers. If maintenance is not furnished, \$9 a month is to be added for room and \$20 for board. The union reserves the right to review the discharge of its members. It is affiliated with the American Federation of Labor.

The advent of labor unions into the hospital field raises a fundamental question. Hospitals will not enjoy the prospect of having to deal with union representatives concerning the employment, promotion, discharge, salaries, and living and working conditions of their employees. Whether we like it or not, however, every indication now is that the growth of collective bargaining in the United States, unless there is a change of trend, will eventually embrace our institutions. As long as the Labor Relations Act is in force, it is illegal for the employer to use coercion to prevent the organization of employees. Hospital administrators, therefore, must be prepared to develop a technique for dealing collectively with employee groups.

If unions are to win the public support which is necessary to their success, they, too, must take full cognizance of the unusual character of the hospital. The voluntary or government hospital is not operated for profit. The care of patients must go on. Human lives are at stake. No community will tolerate acts by the unions which endanger these lives.

But, while the picket and the strike are customarily the ultimate weapons of the trade union, their use is rare in comparison with the frequency of peaceful negotiation. In other activities that are crucial to social welfare, unions and employers have learned to settle their differences in nearly every case without resorting to strikes, lockouts, picketing or violence of any form and without crippling essential public services. Railroads and fire and police departments are examples that readily come to mind.

If hospitals wish to prevent or delay the unionization of their workers, they must voluntarily assume the obligation of seeing that these employees receive fair treatment. There has been

a tendency in some hospitals to exploit the non-profit character of the institution beyond reasonable limits. Some institutions, through bad business management or lack of proper public relations work, have gone into debt and put most of the load on to their employees. Some have acted on the assumption that the cheapest help was the best. They probably have about the quality of service for which they paid.

The hospital field as a whole suffers from the attitude of this penny-pinching minority group. When these institutions learn to appreciate and practice the economy of good wages and good working conditions, the move toward unionization of hospital employees will lose much of its force.

Scrutinizing the Deficit

DEFICITS are not always inevitable like the coming of a national holiday or the setting of the sun. A deficit may be a disgrace or a token of bravery in meeting a community need.

To dissect the deficit is often illuminating. In what department or activity was the greatest loss experienced? With more careful management could a portion or even the entire loss have been prevented? If a costly activity is not appreciated by the community perhaps it is not needed. If a needed service is too expensive for the average patient to enjoy mayhap a reduction in its cost without curtailing its usefulness could be brought about.

If and only when a service can be adjudged indispensable to the common good, may the executive continue it at a financial loss. This statement may apply to the hospital as a whole as well as to any of its parts.

Your Hospital and Physical Therapy

EVERY hospital except the very small ones should have a physical therapy department. Some may question such a sweeping statement. Let us listen to the opinions of outstanding physicians.

Dr. Harry E. Mock of Chicago states: "Physical therapy should not be limited to office practice or to the ambulatory case. It should start, in many instances, while the patient is still in the hospital, during the early days of his recovery; therefore, every modern hospital must be equipped with a physical therapy department supervised by a physician who understands this

work and manned by trained technicians who can administer it."

"I look to the more general and intelligent use of physical therapy, not by physical therapists but by physicians, as the means of making the next great advance in fracture treatment," says Dr. Philip D. Wilson, New York orthopedic surgeon.

A St. Louis plastic surgeon, Dr. Vilray P. Blair, adds further: "The application of physical and occupational therapy plays an indispensable rôle in the care of many patients who have to undergo extensive plastic repairs of defects."

One of Philadelphia's foremost internists, Dr. William D. Stroud, recently declared: "It is my sincere opinion that physical therapy must take its place at the head of the various forms of treatment directed toward arresting the progress of cardiovascular disease."

Finally, the chairman of the American Committee for the Control of Rheumatism, Dr. Ralph Pemberton, recently wrote: "The field of physical therapy is not only the oldest but one of the largest therapeutic fields in medicine, having application to a wider variety of conditions than is the case with almost any other single group of agents."

These statements could be multiplied indefinitely. Leading physicians today regard physical therapy as an indispensable adjunct to proper medical and surgical care of hospital patients. A hospital without a physical therapy department cannot fully serve the patient's welfare.

Furthermore, such a department is an excellent source of revenue. In a Middle Western hospital which averaged 108 patients daily the gross income for the past year from the physical therapy department was over \$9,000, with expenses of about one third this amount. Of course, the staff understands and uses physical therapy.

In considering the establishment of a physical therapy department the attitude of the staff must be clearly ascertained. Their thoughts on this subject may have changed considerably in the last few years. Over ten years ago the American Medical Association established a council on physical therapy to examine and pass upon physical therapy apparatus. This council has also undertaken a campaign for the education of the medical profession in the use of physical agents. Frequent articles in the medical journals, two editions of the "Handbook of Physical Therapy," and scores of scientific papers on physical therapy presented before medical societies have paved the way for the wide utilization of these fundamental measures.

Any hospital that does not have a physical therapy department should make a start soon. This need not involve large expense. A member of the council on physical therapy recently stated that heat, massage and exercise are the three most important agents for physical therapy. These physical agents can be used with little apparatus and even this can, if necessary, be made by hospital employees. Designs for its construction can be obtained from this magazine.

This does not mean that manufacturers' apparatus should not be used. The profitable physical therapy department previously mentioned is well equipped with such apparatus. Short wave diathermy machines, for instance, give a penetrating form of heat that cannot be duplicated by any other means. Ultraviolet radiation lamps are useful in many conditions.

But to start a physical therapy department expensive apparatus is not necessary. It is wise to spend the first money on good technical personnel even if they use homemade apparatus. As the department expands buy such apparatus as is required and will be used. The council on physical therapy issues a list of accepted apparatus. As physical therapy machines may be inefficient or dangerous the hospital administrator should restrict his purchases to approved products.

The most important factor in success is efficient personnel. The department should be in charge of a physician with real interest and some special training in physical therapy. Because so large a percentage of physical therapy is the use of massage and exercise which require a thorough knowledge of anatomy, physiology and pathology, the technicians should be graduates of approved schools of physical therapy.

The MODERN HOSPITAL thoroughly believes in the importance of this department. Articles have been and will be published on physical therapy departments in various hospitals. If these do not solve your problems, our consulting staff will help you on application.

The Intern and Ex-Intern

THE policies governing the selection of interns which are in force throughout the institutional field are almost as varied as the number of hospitals considered. In some the selection of the resident staff is determined wholly by social, financial and, lastly, scholastic standing. In others, a thorough and searching examination of both a practical and a didactic nature is held.

Some institutions will not accept a young graduate in medicine unless they can be assured that once the hospital course is finished the physician will settle near by in order to act as a feeder to the hospital giving him training. Other institutions actuated by recommendations of the medical staff frown upon the likelihood of an intern settling near by because of the increase in the number of doctors in the community which would result from this practice.

Young physicians are likely to be of little benefit to the hospital for at least a decade and it seems that there should be other and more important considerations than the filling of private rooms which may result ten years hence. There really is but one bona fide standard by which to select an intern staff. This is the probable effect of the residence of a physician in a hospital upon the patients he will serve.

In Pennsylvania the state board of medical education and licensure does not approve of importing physicians, trained outside the state, for internship. This may or may not be a wise policy. The fact remains that until the terms of eligibility for admission to practice are widened in this state internships must be provided for all those graduating from schools located therein. After educational requirements laid down by the state have been satisfied it seems that policies as to residence and method of selection should be left to the individual hospital.

A Good Directress of Nurses

THIS is not an unusual need. More and more hospitals are searching for high-grade, well trained, ethical, tactful women who are educationally and administratively qualified to head their schools for nurses.

A good directress of nurses is a jewel to be cherished. She must be, first of all, so skilled in administration that she realizes that her school cannot exist as a small kingdom in the midst of a greater one without any lines of authority reaching from without inward. Her educational vision must be of the keenest, her tact of the highest grade, her ideas of discipline unswerving and yet not militaristic.

To her pupils she must represent teacher, counselor and friend and yet there must never exist too great a degree of familiarity between herself and her assistants and the members of her school. Is it too much to suggest that she should also be convinced that schools for nurses may be efficiently conducted because of the hospital rather than in spite of it?



WHEN the Sisters of Mercy decided to build a modern private hospital in the city of Melbourne, they spent much thought on preliminaries. In Melbourne all private hospitals were established in residences which had been converted and added to for hospital purposes. They were often located in beautiful gardens, but were necessarily inconvenient.

Two of the Sisters had previously visited America and been inspired by the hospitals they had seen. The question of a site was most important, and after much argument it was decided to build in the city area rather than in the suburbs to render the hospital accessible to the doctors' consulting rooms. This decision has been much appreciated and the many advantages gained have compensated the Sisters for the cost of the Eastern Hill site, with its views over the beautiful Fitzroy gardens.

The question of the capital available for building was carefully studied, and it was found possible to prepare a budget for the construction of a hospital of 120 beds only.

The area of land was limited and the most useful way of using it appeared to be the construction of a unit hospital restricted to the number of beds originally planned, with no provision for expansion. This is contrary to the view held by many that a hospital should always be built to provide for expansion, but in this instance the

Going Modern in Melbourne

By A. G. STEPHENSON

Stephenson and Meldrum, Architects, Sydney, Australia





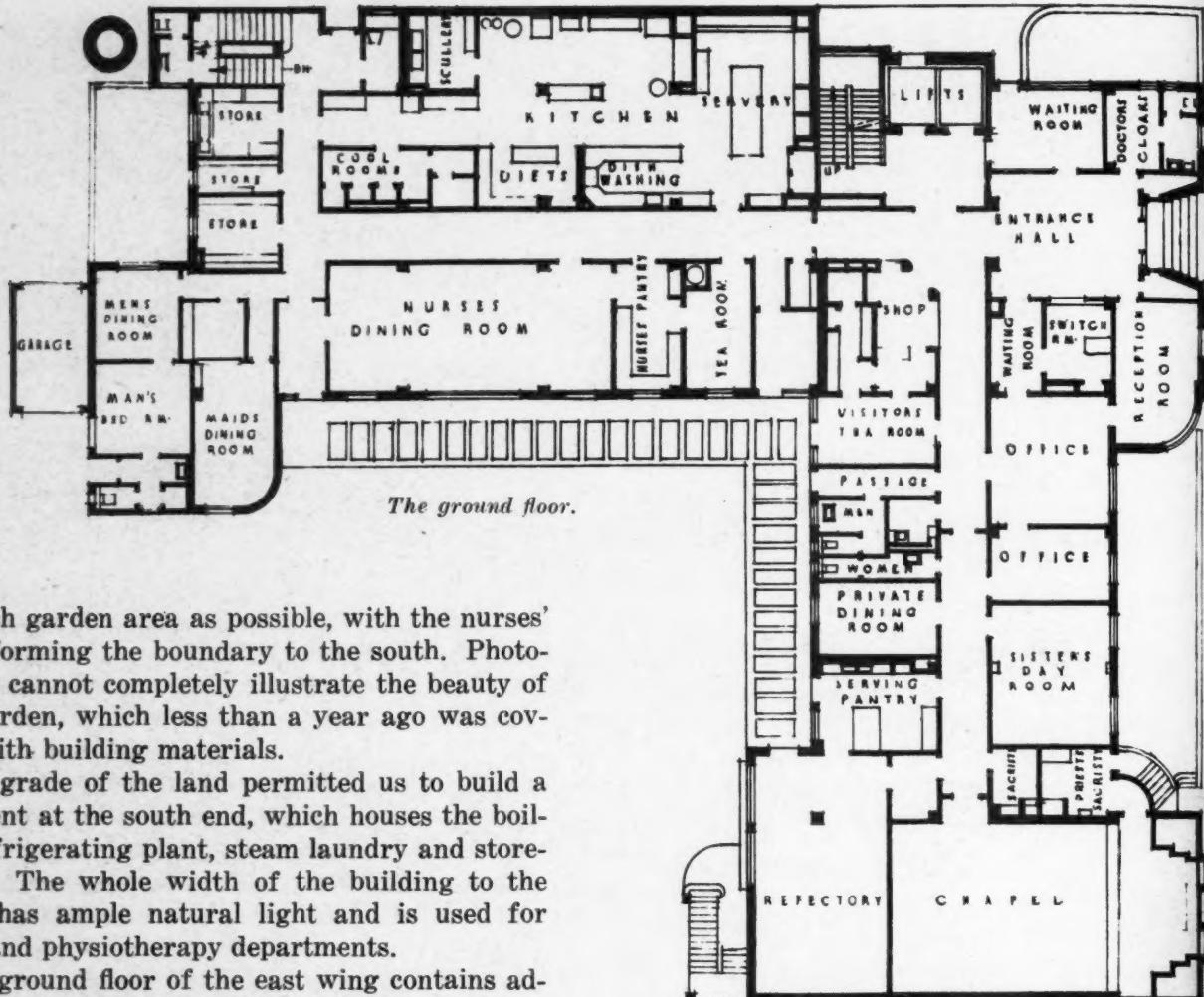
Sisters wisely argued that 120 beds was an economical working unit and if expansion proved necessary, and there were sufficient nursing Sisters of the Order available to staff it, another similar hospital could be built in one of the inner suburbs.

Mercy Hospital was filled two months after its opening, and has been running at capacity since.

The hospital was planned on the American principle of central service for food and sterile supplies, which in my judgment is the finest contribution to administrative development in the hospital world, particularly when applied to small institutions.

The shape of the plan was designed to provide





The ground floor.

as much garden area as possible, with the nurses' home forming the boundary to the south. Photographs cannot completely illustrate the beauty of this garden, which less than a year ago was covered with building materials.

The grade of the land permitted us to build a basement at the south end, which houses the boilers, refrigerating plant, steam laundry and store-rooms. The whole width of the building to the north has ample natural light and is used for x-ray and physiotherapy departments.

The ground floor of the east wing contains administrative offices, the Sisters' refectory, chapel and day rooms. The hospital abuts on a lane on the west side, with a service entrance in the south wing. The kitchen and stores are in the ground floor in this wing, the main kitchen in the center, with a group of storerooms planned at the south end and the central service pantry near the junction of the two ward wings. On the opposite side of the corridor is the nurses' dining room and the

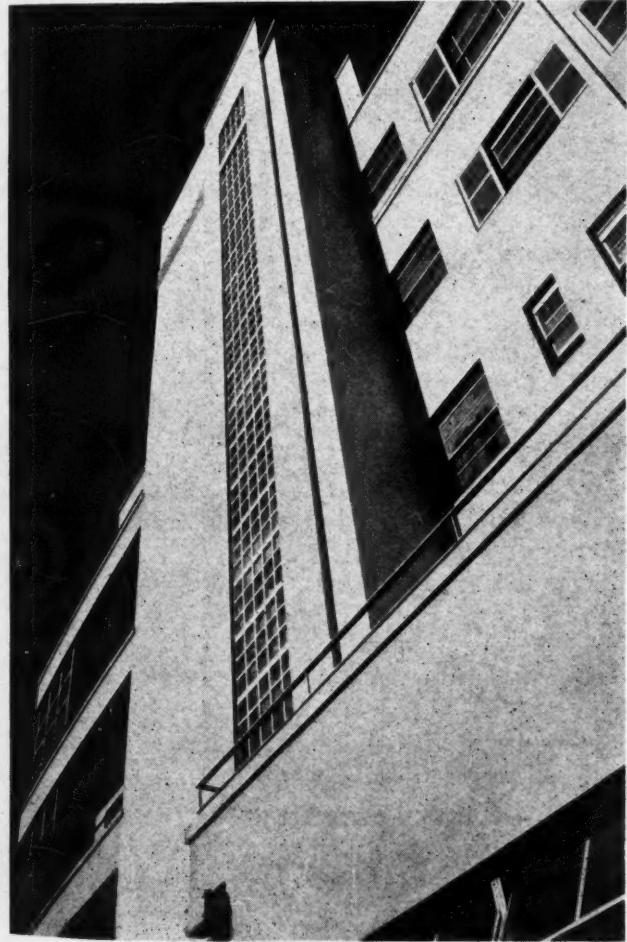
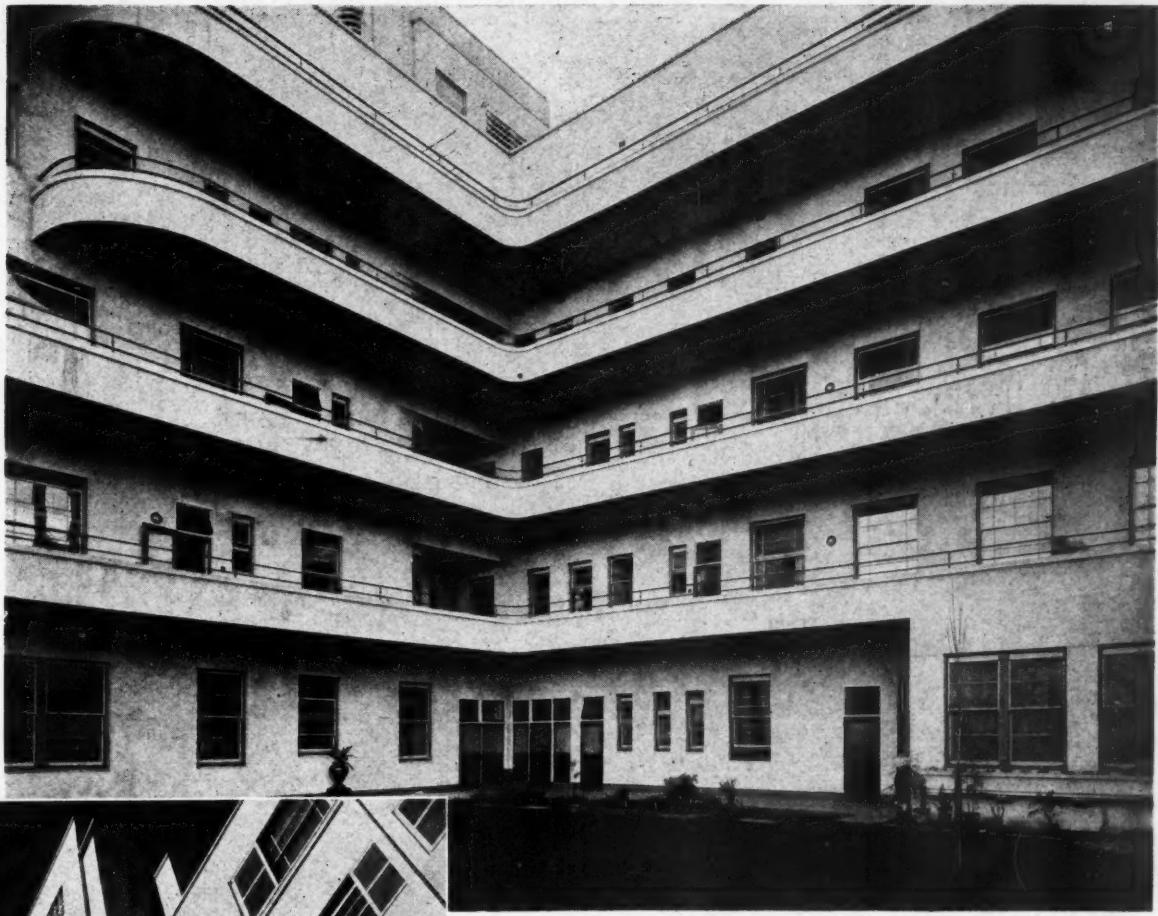
staff dining room. The patients' rooms are on the four upper floors.

The south wing of the third floor is the operating suite and the south wing of the fourth floor the birth room suite. The maternity beds are grouped on this floor.

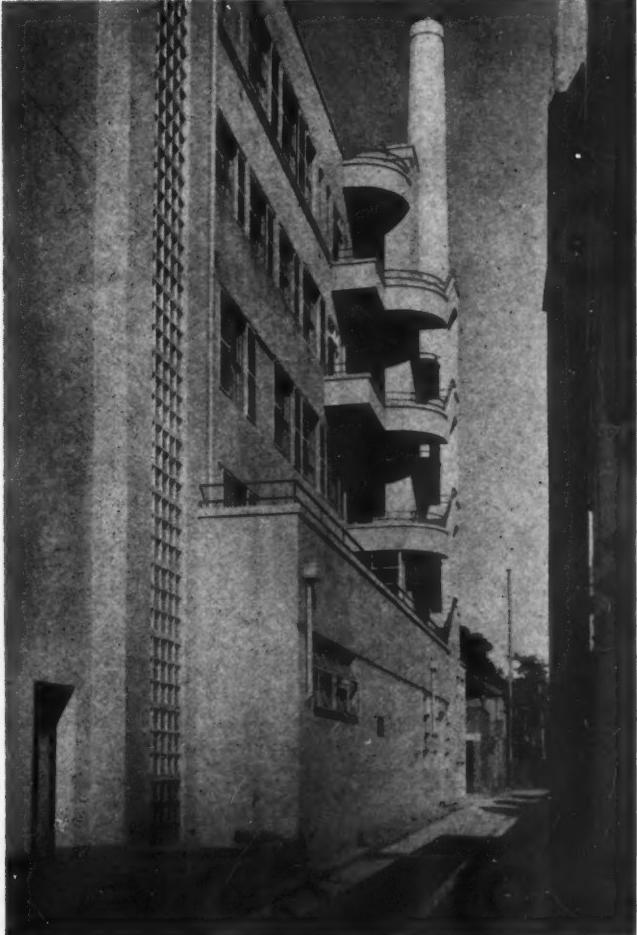
The operating suite is a complete departure from the usual practice in this country and in some details, from American practice. A disconnecting lobby is planned across the full width of the building, completely separating the operating suite from any hospital traffic. This is used as a scrub-up lobby. In front of these fittings are wide view windows through which preparations in the operating rooms may be supervised.

The sterilizing room between the operating rooms is accessible only from this lobby. During operations a nurse is stationed in this room and serves both operating rooms through sliding windows. This arrangement eliminates the possibility of any unsterile person entering the operating field and has proved to have several other advantages over any system of direct access. The principle is gaining ground in Germany and Cen-

| DEPARTMENT AREAS AND THEIR PERCENTAGE OF THE WHOLE | | | |
|--|--------|-----------------|---------------------|
| Hospital Building | Area | Sq. Ft. per Bed | Percentage of Whole |
| Wards..... | 22,103 | 190 | 30.8 |
| Utilities..... | 4,228 | 36 | 5.9 |
| Medical services, operating suite, birth room..... | 3,958 | 34 | 5.5 |
| Administration, kitchen and dining rooms..... | 7,806 | 67 | 6.28 |
| Mechanical, power plant etc..... | 2,725 | 23 | 3.7 |
| Sisters and staff accommodation..... | 4,510 | 39 | 10.8 |
| Communications: stairs, unusable space..... | 26,729 | 230 | 37.9 |
| | 72,059 | 619 | 100 |
| <i>Nurses' home</i> | | | |
| Total area..... | 16,481 | 142 | |
| Grand total..... | 88,540 | 761 | |



The cantilever balconies which are a striking feature of Mercy Hospital provide open air accommodations for patients without cutting out sunlight from the wards, as do those that are supported by piers or by columns.



tral Europe and it was from this source the architects derived their inspiration.

The nursing group is based upon what I regard as the best American practice. It is interesting to note that Mercy is the first hospital in Australia in which the method of bathing babies by means of sprays has been adopted, and it has proved an unqualified success. In the first instance we tried to rely on a thermostatic valve to

provide open air accommodations without cutting out sunlight from the wards as do those supported by piers or columns. This was the first instance in the commonwealth where this form of construction was applied to hospital development, for which, after all, it is preeminently suitable. It has proved an extraordinary success and gives a sense of freedom and airiness that is incomparable in value.

This choice of construction, coupled with the fact that the main building housed all the service departments, necessitated extreme care to prevent transmission of sound. All machinery is set on heavy insulating pads of cork and all the partitions are built with acoustical material between the terra cotta and the concrete.

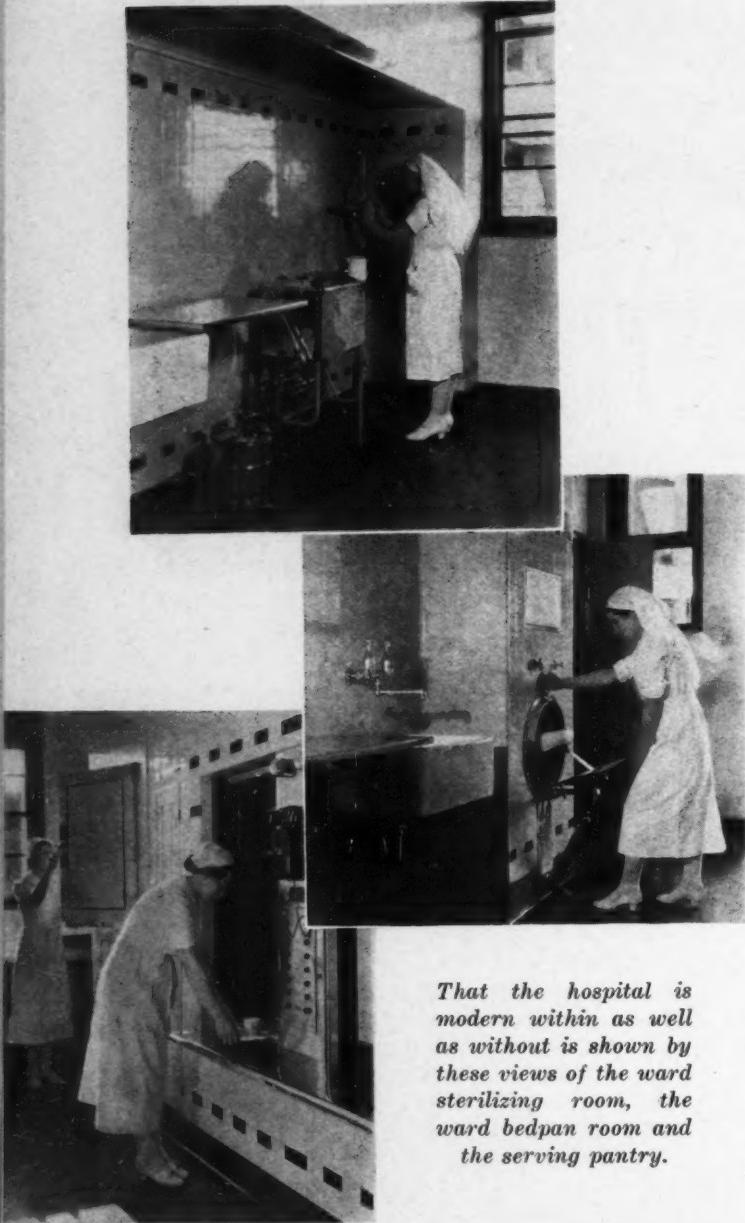
Oil Is Used for Fuel

Due to its price, oil is not an economical fuel to use for large boiler plants in this country. The advantages of its use, such as cleanliness and the saving of bunkerage space, however, decided us to recommend its use for this plant. Although at the time it was estimated that the fuel costs would exceed those of coal by approximately £800 a year, actual experience in working the plant has proved that the extra cost is slightly less.

A complete system of recording apparatus is installed in the power house. The steam and oil are metered and charts show the load variation, a considerable help in a better understanding of the hospital's needs. Every motor in the hospital is brought back to a board in the plant room where the engineer, by means of a system of indicator lights, can see which motors are running throughout the hospital and whether or not they are out of order. The architects first tried out this system at St. Vincent's Hospital in Melbourne where the boiler house is some little distance from the hospital and it proved there to be of great assistance to the attendants.

The installation of a steam laundry for this hospital did not seem an economical arrangement, but the Sisters wished to have this work under their own control. In order to justify its installation they centralized their laundry work, bringing the linen from St. Benedict's, their other hospital, to be washed in the Mercy laundry.

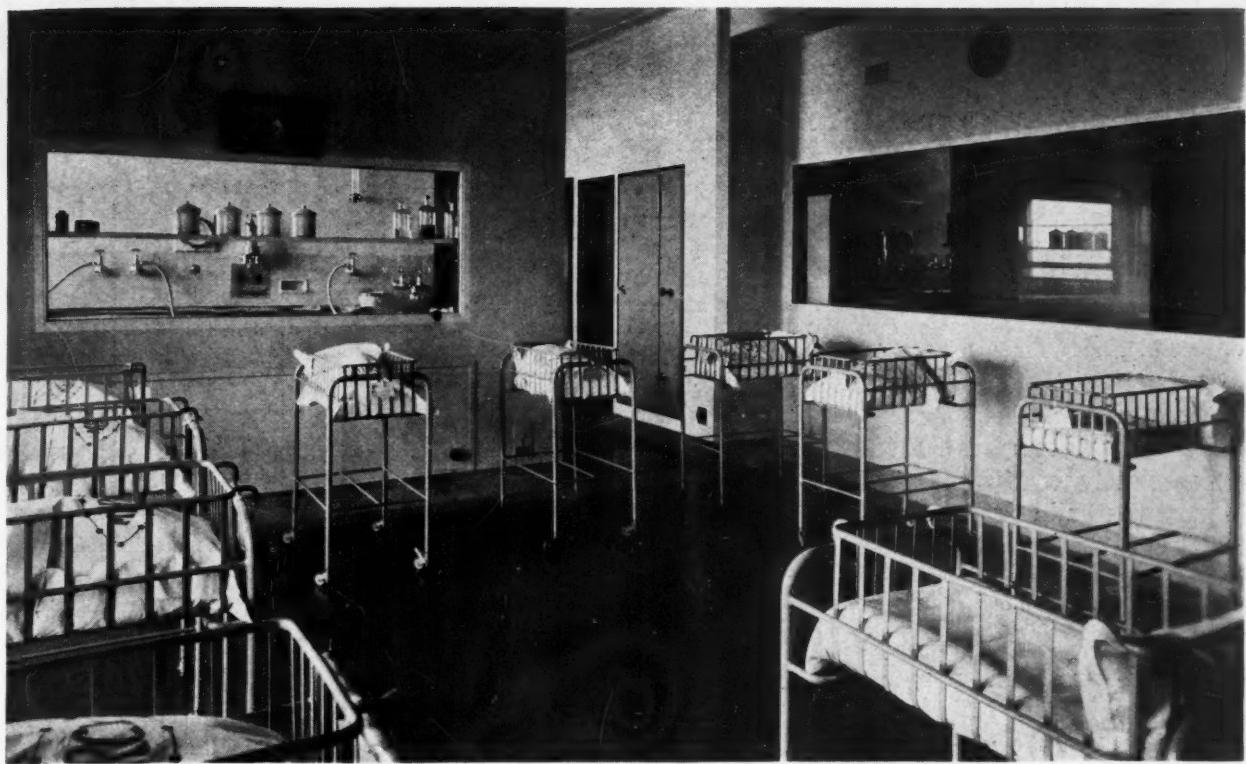
Finances would not permit the installation of an air conditioning plant, but we believe that within a short space of time air conditioning will be regarded as an essential feature of hospital design, if not in wards certainly in the operating, x-ray and service departments. At the new 150-bed intermediate wing of the Royal Prince Alfred Hospital, Sydney, air conditioning equipment is being provided for twenty private rooms. It is



That the hospital is modern within as well as without is shown by these views of the ward sterilizing room, the ward bedpan room and the serving pantry.

produce uniform temperatures for the sprays, but it was found that the adjustment was not fast enough, owing to the great variation on water pressures, so it was necessary to install a mixing tank where a quantity of storage was available that eliminated any risk of scalding.

The building frame is of reenforced concrete and its chief features are the cantilever balconies. These are essentially suitable for hospitals as they



This picture of the nursery also shows the babies' wash room where babies are bathed by the spray method.

expected that this innovation will stimulate public interest and prove a decided advantage in the nursing of very sick patients.

Most of the standard nursing equipment now in use in similar American hospitals is in use at Mercy, for nursing equipment is more highly developed in America than anywhere else in the world. Linen chutes, call systems, all forms of built-in cabinets and built-in bedpan washers are installed throughout. All the service rooms, kitchens, operating and birth rooms are equipped with complete mechanical ventilation, a principle which was introduced to hospitals in this country only seven or eight years ago. It is now of course regarded as essential.

All the world over noise in hospitals is condemned and it is astonishing that so little provision is made for guarding against this evil. In this country it is due partly to lack of funds, but mostly, insofar as the state of Victoria is concerned, to the strange refusal on the part of the health department to permit the use of sound absorbing material in hospital buildings. However, every endeavor has been made to reduce noise by completely isolating the lift wells from the main structure, using thick linoleums on floors and applying a certain amount of sound absorbing material in the ceilings of rooms from which noise is likely to emanate.

An innovation in lighting has been tried with unqualified success. Ceiling fittings were omitted altogether from single rooms. Special castings

were made to fit over the patients' beds in which the lights may be fixed for general illumination or, if desired, to give reading light in the correct position. It is unlikely that we shall revert to ceiling fittings in single rooms again; we shall rather concentrate on perfecting this type of fitting.

It seems increasingly clear that every effort should be made to render the hospital beautiful. The care that was taken in considering the color schemes, the furniture, access to the gardens and views from the patients' rooms, has without question proved of inestimable benefit both to those

BUILDING AND EQUIPMENT COSTS*

| | |
|-------------------------------------|-----------|
| Hospital building..... | \$284,075 |
| Nurses' home..... | 63,305 |
| Mechanical contracts and lifts..... | 70,104 |
| Furnishings and equipment | 40,377 |
| | \$458,561 |
| Land, approximately..... | \$28,000 |
| Fees, approximately..... | -\$51,400 |
| Total..... | \$564,961 |

*At the time of writing the exchange between Australia and America stood at \$3.96 to the Australian pound. These have been converted to dollars at this rate.

RUNNING COSTS OF MECHANICAL EQUIPMENT

| | | |
|-------------------------|------------|-------|
| Steam..... | \$ 774.20 | 68% |
| Gas (cooking)..... | 89.10 | 7.92% |
| Electricity: Lifts..... | 25.74 | 2.28% |
| Power..... | 154.44 | 13% |
| Lighting..... | 91.08 | 8% |
| | \$1,134.36 | 100% |

who work in the hospital, to the patient and to the public, who are inspired with respect for an institution where these standards are set.

The whole of the hospital furniture, curtains, rugs and soft furnishings were designed and selected by the architects, and consequently a homogeneous unit has been created, which can hardly be the case when the selection of fittings is left in the hands of those not completely cognizant of the intentions and design of the building.

In British countries the advance from the old type of hospital has been gradual and the members of the general public in Australia are naturally rather isolated from possibilities of seeing the general world development in these matters.

More insulation should have been placed on the ceiling of the boiler room to ensure that no trouble would arise from the heating of the floor above, where the storerooms are located.

Three food lifts should be provided in central tray service stations for a hospital of this size.

At least one consulting room should be provided for doctors on each floor.

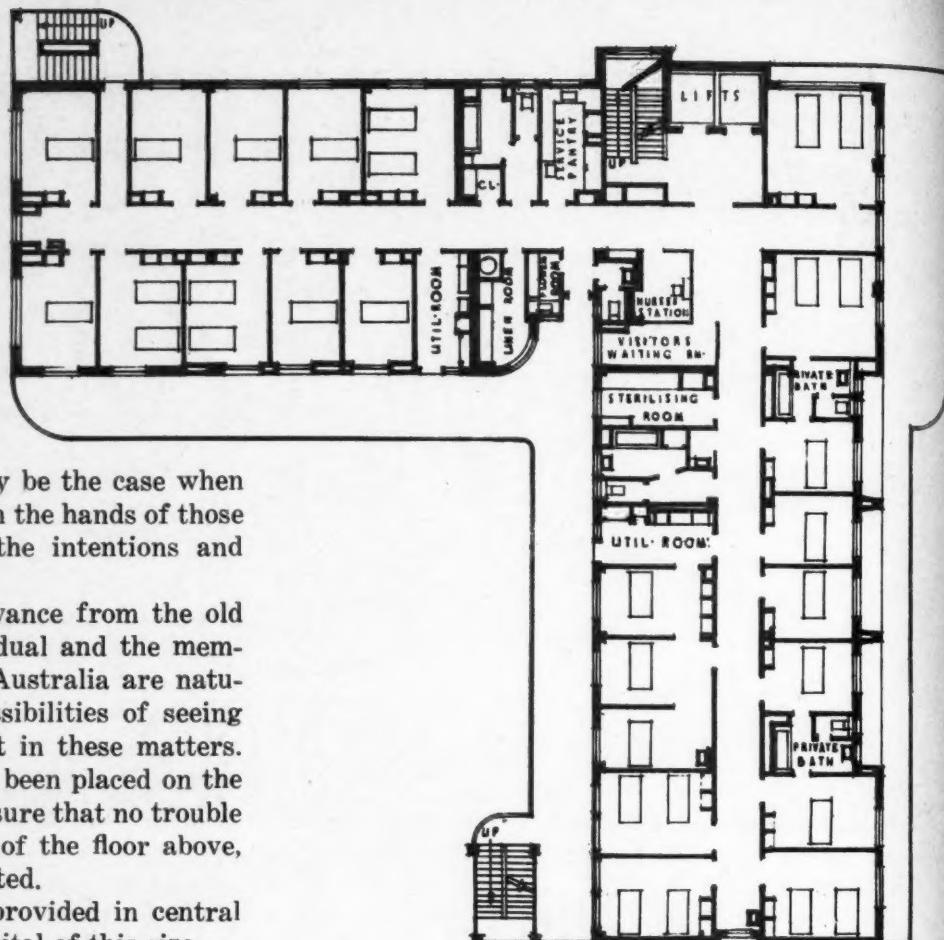
Experience has shown that some confusion exists in returning to surgeons their own instruments without mixing them with others. This is due to the fact that only one sterilizing room was provided between each two operating rooms.

In addition to changing rooms for surgeons adjoining the operating suite it seems advisable, in this country at any rate, to provide a tea room or lounge where surgeons may have tea and a rest.

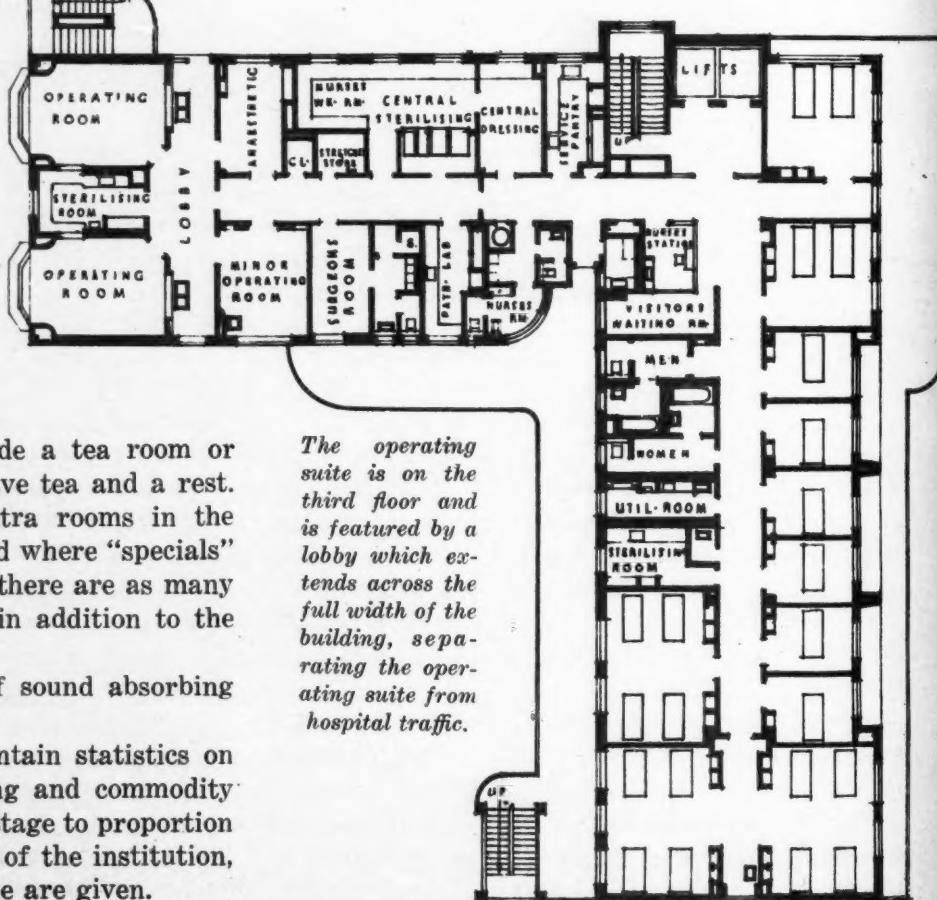
A greater proportion of extra rooms in the nurses' home should be provided where "specials" may be housed. At the Mercy there are as many as twenty specials at a time, in addition to the general nursing staff.

More use should be made of sound absorbing materials.

The accompanying tables contain statistics on space allotment and on building and commodity costs. It is not possible at this stage to proportion the whole of the running costs of the institution, but those on the mechanical side are given.



The second floor, shown above is devoted largely to patients' rooms.



The operating suite is on the third floor and is featured by a lobby which extends across the full width of the building, separating the operating suite from hospital traffic.

We Need Help

By MAURICE DUBIN
Director, Mount Sinai Hospital, Chicago

TWO years ago, when I made a study of state aid to hospitals, the principle of state responsibility had for the greater part been clearly accepted in Canada. In the United States, however, at that time, with certain exceptions no general recognition of such a principle could be noted.

The exceptions were Pennsylvania, Maine, Connecticut and Mississippi. Pennsylvania was the outstanding example of a comprehensive plan of state aid both in scope and in amount. A number of other states, while without state aid, reported subsidies by other divisions of government, such as counties, townships or municipalities. While no complete figures were collected to show the total amount contributed through government subsidies in relation to the amount expended by nongovernment hospitals for free care, sufficient evidence was available for assuming that it constituted but a small part of the total in the United States.

The Need Is Urgent

Granting that the picture has changed in the past two years to a certain extent by payments for hospitalization of the sick on relief, the need still definitely exists for nongovernment hospitals to clarify and bring to a focus the necessity for an equitable plan of government subsidy for the care of the indigent sick. And the need still exists for at least four major reasons:

1. Because of the general inadequacy of the payments now being made. In no instances, even where relief commissions make payments for hospitalization and out-patient care, do such payments meet the costs of the service rendered.

2. The uncertainty that attends the general relief programs with their short range planning and shifting of clients from one category to another.

3. The certainty that even the long awaited recovery of business bringing back employment will at best reduce the demand for material relief but for a long time will not provide the earnings necessary to purchase medical care, at least for hospitalized illness.

The plight of voluntary hospitals is here well expounded by Mr. Dubin who gives four reasons why a sound plan of government subsidy must be adopted to provide care for the indigent sick in nongovernment hospitals

4. The need for bringing empty hospital beds and sick patients together.

Hospital trustees and administrators, as well as those responsible for raising community funds or other agencies subsidizing hospitals, face the fact that some more certain way of providing hospital budgets must be found. Hospitals should through organization and education bring home to their respective communities the fact that one dependable prop for the hospital is the adoption of a sound plan for subsidizing the care of the indigent in nongovernment hospitals through tax funds. We do not advocate this as the sole measure of support—current earnings, government subsidies, endowments, gifts and legacies and group hospitalization, are all part of the plan. The philosophy of the voluntary hospitals is not to unload their entire burden, as it were, on to the shoulders of government or tax funds. But we have reached a point where some form of support of nongovernment hospitals through tax funds is desirable and essential.

The time is past for purely academic discussions regarding acceptance of tax funds; the possibility of their decreasing other sources of revenue; the danger to hospitals in the political administration of such funds; the danger of lessening the incentive for private philanthropy, and other hazards, real or imaginary, involved in a system of government subsidies.

The time is past because there is sufficient evidence at hand in places where such a system is in operation that these dangers are avoidable and more imaginary than real. Dr. George F. Stephens, Winnipeg General Hospital, former president of the American Hospital Association, in discussing this question at the Detroit meeting of the American Hospital Association said, "We have

been in receipt of state aid and municipal aid for twenty years and I do not think we have lost anything by it. I have no fear of losing our independence. . . . In some provinces the municipality makes a subsidy for all patients on the basis of all beds, on the principle that a person who is able to pay his way is entitled to have a bed ready for him.

"There has been a good deal said about the politician and what he does. Politicians are our best friends. If you make it expedient, the politician will help you, instead of depriving you of what you think are your rights. In our legislation, we are not afraid of losing our independence because the amount given, which varies from \$1.75 to \$2.50 a day payment by municipality and the grant of 50 cents a day for the province, as a rule is not sufficient to cover the costs. Any recognized hospital taking in public patients is in receipt of the statutory grant. No distinction is made nor is it an act of grace, it is a right and we find it has been working in the provinces for twenty years."

From personal experience of about ten years in Pennsylvania and New York with some form of government grant, I can endorse this statement.

But I also believe that we are past the debating stage regarding the hazards because we have no alternative. We have come to the realization that relief on a general scale whether it is material or medical is no longer a problem for private philanthropy to cope with alone.

Now Time to Act

The problem then becomes one of procedure and tactics if we are to take it out of the realms of academic discussion. How can we induce government units whose costs have gone up — federal, seven hundred and sixty millions in 1913 to four billions in 1930 and probably six billions or more in 1935, state governments, three hundred millions in 1913 to two billions in 1932 and perhaps three billions in 1935 — to take upon themselves additional burdens, especially in the light of the tremendous pressure from certain elements to curtail government spending and taxation?

We must seek our answer in the postulate that we must do it if the voluntary hospitals are to be able to continue to serve the needy sick. With such an unselfish motive in view and with the glorious past record of voluntary care of the indigent sick, voluntary hospitals can create a public sentiment that certain sums from existing tax funds should be allocated for hospital care.

Before doing so, however, hospitals will have to agree amongst themselves on their objectives and the methods of carrying on towards the ob-

jectives. This presupposes the organization of hospitals into cooperative groups or units for cooperative work and action.

In considering objectives, we should define in our own minds what it is we are after. We use the terms government subsidy, state aid, municipal aid, county aid, lump sum grants and per diem payments. Would it not be better for us all to agree that we are not asking for lump sum government subsidies, but are proposing that voluntary hospitals shall be paid for service rendered to the indigent sick on a per diem basis for actual service rendered and that such payments shall be made preferably through county units? We believe that public opinion as well as political powers would find it much harder to refute the justice of such a claim than the more general one of a lump sum subsidy. It would not lend itself so readily to the charge of another lobby to raid the public treasury.

How to Proceed

With the objective agreed upon, hospitals should organize themselves into councils within each state, preferably on a county basis. These county hospital councils should then take upon themselves the task of convincing the citizens of their respective counties that the municipality or county where the patient is a resident, shall pay for his hospital care if he is poor and cannot pay. These county hospital councils can act as a clearing house for data relative to the amount of service being rendered in any county by the voluntary hospitals in that county. The county hospital councils through a state association or council should simultaneously endeavor to get state action started in making funds available to counties for reimbursing hospitals.

I propose that the attack for payments for care of the indigent sick be launched in the direction of both county and state payments, because I believe much time will elapse before the per diem allowance even if granted by both units of government will be ample to reimburse the hospital for the cost of the care and service rendered. We should at the outset approach the matter with the feeling that half a loaf is better than none, the amount per diem to be paid should not be of so much importance to us as the establishment of the principle.

By bringing the state as a unit of government into the picture, we would have a valuable ally in times of general distress when federal funds become necessary to cope with great problems of relief, in helping see that federal funds are available for medical relief as well as material relief. At least they would help oppose action which

would make federal funds only available to states conditional on their not being used for medical relief.

In the Illinois, Indiana and Wisconsin area efforts to bring about uniform recognition of the principle of government responsibility for the care of indigent sick, do not raise an entirely new issue. That the principle of government responsibility for the care of the sick has already been accepted in these states is evidenced by the fact that we do find municipal, state and county general hospitals. We ask an extension of the principle of government responsibility for the indigent sick, including those in the care of voluntary hospitals.

The Ice Is Broken

Even in this respect, the ice has already been broken by payments through state relief commission funds to voluntary hospitals for relief clients. In Wisconsin, under the general hospital law, if the county judge finds that the needs of an indigent patient referred to him for hospitalization in the state hospital at Madison can be cared for equally well at home, and at no greater cost to the county, he may order such local hospitalization at county expense.

In Indiana in the past some enabling acts have been passed by the state legislature which make it possible for a city, county or township, where there is no public hospital, to levy and collect a special tax and appropriate money to hospitals organized not for profit from such collected taxes. These taxes vary from 3 cents to 7 cents on each hundred dollars of taxable property in such cities, counties or townships.

In Illinois in 1934 one of the private hospitals received a verdict against the county in a suit for payment for the care of indigent patients.

We do not therefore face a hopeless task; quite the contrary, there is just ground for belief that if the hospitals coordinate their efforts, they may expect a reasonable measure of success in bringing about the acceptance of the principle of a payment on a per diem basis by the responsible unit of government for the care of the indigent sick in voluntary hospitals. Such organized and coordinated activities would help in bringing home to respective communities not only the value of the service rendered by voluntary hospitals, but the tremendous cost of plant and equipment that would have to be provided by the county or municipality were the voluntary hospitals unable to provide the service.

Organization and activities in this direction will necessarily take the time of administrators and trustees — time that some of them will feel

cannot be spared from their hospitals. But it is a job that will be done only to the extent that they will interest themselves in the matter and devote time to it. In the long run it will probably be more fruitful in helping provide reliable hospital support than some of the blind alleys that have been followed. Revenues from gifts and endowments will, to be sure, still be available, perhaps not in larger amounts than before, but such funds will be needed for research, improvements of techniques, new equipment, replacement of plant and for helping reduce costs to patients of moderate means.

A report by the Pennsylvania state welfare commission on state aid to private charitable institutions and agencies is of significance to those who favor a system of direct state aid. It presents and reviews the experience with this form of government subsidy in the state having the most extensive and best experience with it. Pennsylvania now grants state aid to voluntary general hospitals in the amount of three and a half million dollars per annum.

I do not advocate the county as the sole unit for government subsidy. In any state where there is no acceptance of the principle of government responsibility, the approach would be easier if made through and to the unit of government responsible for relief in any particular locality. With that unit committed to the principle even by a comparatively small per diem payment, the state as the larger and perhaps richer "uncle" could also be induced to contribute. But in any event, hospitals in cooperative groups, associations or councils should present a united front.¹

¹Read at the meeting of the Tri-State Assembly, Chicago, May 6 to 8, 1936.

"Closing Out" Salesmen

The hospital buyer should beware of purchasing surgical supplies from traveling salesmen who carry a small trunk full of various items and offer them at an attractive cash price.

Such salesmen have glib tongues and readily explain why they wish to close out their assortment. Inspection will show the articles to be of unknown vintage, and if they are purchased the user will soon find the quality far below par. The salesmen leave no address, so there is no chance of an adjustment; neither will they be seen again, for having made one sale, they know only too well that repeated business cannot be obtained.

Dividends will be obtained by confining purchases to representatives of recognized firms and, as far as possible, buying articles manufactured by reputable firms. The initial price may not be as low, but the better quality and satisfactory business relationships will prove economical.—Lucius R. Wilson, M.D., John Sealy Hospital, Galveston, Tex.

What Others Are Doing

Former Storage Space Now Isolation Unit

Faced with increasing demands for service, many hospitals are finding it more necessary than ever before to put to practical use every inch of space available. It is surprising, too, what transformations can take place by making the most of odd corners and quarters used for storage or other non-productive purposes.

In St. Vincent's Hospital, New York City, for example, need developed for a complete isolation unit, particularly for use in connection with the obstetric department. Existing facilities provided only for the overnight care of the patient.

At the extreme end of the men's ward was considerable space, forming a closet such as is found in older buildings. This was being used merely for storage. Especially advantageous was its location in relation to the obstetric department on the floor above. So doors were installed to ensure complete privacy and the space arranged to form a suite comprising private room, bath and modern utility room, also a closet for ice box, gas stove and similar equipment. Wooden baseboards were removed and plaster substituted. New linoleum was laid on the floor and the walls were freshly painted.

The cost, outside of the necessary installation of certain equipment in the utility room, was small, work being done principally by hospital employees. Room is even available for expansion should the need arise. A wall dividing the main room will provide accommodations for two private patients.

Don't Overlook Your Clubs, Warns Albany Hospital

Club consciousness is a paying proposition, according to Albany Hospital, Albany, N. Y., where it has been incorporated into the good will program of the institution. Last year, explains E. W. Jones, executive director of the hospital, the hospital entertained the Albany Industrial Club, the Junior Chamber of Commerce, the Chemical Society and the New York branch of the Statisticians Society. Each group was taken on a tour of the hospital and then served dinner. Later short talks were given

on hospital problems by members of the medical and administrative staffs, and the groups invited to ask questions. Often these question and answer sessions lasted from eight until ten o'clock, and when each group departed it had some conception of the part a hospital plays in the life of a community.

Sell Benefit Tickets for "The White Angel"

Florence Nightingale is helping to swell the coffers of the international foundation formed in her honor. When "The White Angel," a film portrayal of her life in which Kay Francis is starred opened in Chicago, fifty-six hospitals in the city and surrounding suburbs, the Chicago chapter of the American Red Cross, the Visiting Nurses' Association and the Infant Welfare Society organized to sponsor the sale of special admission tickets. A percentage from the proceeds of each special ticket sold is to be donated to the Florence Nightingale International Foundation.

Check List of Services for Patients

When a patient enters a hospital he has but a vague idea of what he may expect in the way of service. He finds himself being charged for items he feels should be furnished free, and a misunderstanding results that sometimes ends in ill-will. Realizing that much hospital criticism rises from just such a cause, Christ Hospital, Cincinnati, decided to eliminate this factor by making it possible for each patient to know just what his room charge encompassed in the way of service.

To do this, says Dr. F. G. Carter, superintendent, the hospital has established a printed form, headed "Agreement with The Christ Hospital." The agreement reads: "In con-

sideration of having been admitted this day to the Christ Hospital for hospital care, the undersigned agrees to pay to the said hospital in return for the services checked in the accompanying list the sum of \$....."

The list is made up of the following revenue producing services: single room; bed in double room; bed in ward; board; general nursing care; ordinary drugs; routine laboratory work; delivery room service; use of anesthesia equipment and supplies; administration of anesthetic; x-ray service (technical); x-ray service (professional); dressings; operating room service; special drugs; special laboratory work; physical therapy; oxygen therapy; basal metabolism test; electrocardiography study; board of special nurses; guest meals; guest room; companion accommodation; clinic service, and telephone.

The agreement goes on to say: "It is understood that there will be additional charges for all services and materials not checked, if they are used, and it is further understood that in all cases where flat rates are granted, hospitalization in excess of the time stipulated will be charged for at the regular rates applying to the accommodations occupied and to the services and materials used."

Buy a Building "Brick"

A nationwide brick selling campaign is being conducted this summer by Hadassah, the Women's Zionist Organization of America, for the building fund of the Rothschild-Hadassah - University Hospital and Medical School, Palestine's first medical center.

Captains and corps of workers are being organized in forty states by the 300 Hadassah chapters. Books of "bricks" of \$1, \$5, \$10 and \$25 denominations are expected to be sold by the thousands. The "bricks" of higher denominations are made of silver metallic paper in anticipation of Hadassah's silver jubilee next year.

The new institution will be composed of three units: a 300-bed hospital, a graduate school of medicine, and a nurses' school and residence.

Probably you can think of one or more practical ways to save time or increase efficiency. The Modern Hospital will welcome your ideas to put before other hospitals

Nurses—What Next?

By BASIL C. MACLEAN, M.D.

Director, Strong Memorial Hospital, Rochester, N. Y.

DURING the past decade hospitals have been singled out as a target of attack for an alleged exploitation of young American womanhood for cheap labor. Every argument has been used except that of undivided surplus in the hospital treasury. Overproduction of nurses, it is claimed, parallels overproduction of wheat and oil and brokers and bank clerks. The cult of "thirty" overwhelms us. It is said that thirty years ago there was one nurse for every thirty doctors and that today we have two nurses for every one doctor. In thirty years, one of every thirty persons in the United States would be a registered nurse. In another thirty years, one of every two persons in this country would be a registered nurse and thirty years later, using the same curve or graph, there would be thirty nurses for every person from Maine to California. Statistics should be salted well with horse sense.

As She Used to Be

Years ago the definition of a nurse was comparatively simple, for nursing then was much simpler than it is today. Many will remember the old definition of a nurse as "a critically unstable compound of nature and science, put together with adhesive tape, safety pins and starch." Cool, clean and crisp as a full dress shirt, she was an authority in emergency and a consultant in doubt and distress. In the doctor's presence, she was his shadow and in his absence, his substitute. As most nursing in those days was done in the home, she was the center of that universe which started to revolve as soon as she took off her hat.

To enter a training school for nursing in those days, the qualifications were rather simple. An average education, a good natural complexion, evidence of birth, a certificate of vaccination and a letter from a clergyman constituted adequate requirements. In the first year she learned how to scrub floors and newly arrived accident cases. She learned the rudiments of physiology, which can be very rude and rudimentary at times, how to make a six-foot sheet cover a seven-foot bed, how to identify bichloride of mercury and how to shake down a pillow or mattress without losing her temper. During the second year she learned how to

shake down a clinical thermometer without dislocating her wrist or putting out her patient's eye, how to make charts for interns to cluck their tongues over and how to hand sponges to doctors in the operating room. In the third year she learned how to make junket and custards, how to nurse forty patients on night duty and how to dodge the superintendent of nurses. Three years of this and she was ready for graduation. Then, barring overdoses, mixed labels and matrimony, her future was secure. This is facetious, of course, for the nurses of yesterday commanded the respect and enjoyed the confidence of both patient and physician.

As She Is Today

We find today, however, that nursing is being lifted by its bootstraps to the status of an academic profession. Nursing organizations have prompted state boards of nurse examiners to be more exacting in their demands and there is so much agitation for revised curricula, increased requirements and higher standards that it is feared by many that a nurse will come to need a bachelor's degree to give a back rub.

The National League of Nursing Education, in its proposed "Standard Curriculum for Schools of Nursing," issued in 1917, advocated 590 hours of instruction. Ten years later, the ideal curriculum provided 825 hours. The one which is provoking so much comment at this moment calls for 1,200 hours of instruction. Most good schools of nursing probably more than meet the most recently suggested curricular hour requirements, but hospitals are constantly harassed by demands to raise the hurdles. The suggested of today becomes the required of tomorrow.

The nurse of today certainly requires more technical knowledge and skill to keep abreast of new developments and procedures in medical practice. It is pertinent to mention, however, that the basic sciences, important though they may be, must never come to outweigh in the nursing curriculum practical instruction in the principles and procedures of bedside care. A detailed knowledge of the amino acids is less important than a dexterity with a drawsheet and as yet neither the patient nor the physician asks that the nurse be a microbiologist.

There may be much truth in the contention of some observant nursing directors that institutional nursing of today does not permit enough time for the development of those niceties of patient care and patient relationship which used to distinguish nursing care in the home. If so, there is perhaps some substance to the story of the physician who, after recommending to his patient the employment of a nurse in the home, received the reply, "Oh, Doctor, I'm too sick for that!"

Physicians who practice in hospitals are frequently critical of the more recent graduates in nursing. Their complaint is that there is too much of the theoretical and too little of the practical in modern nursing instruction, that nursing students are being overeducated and undertrained. This criticism comes not only from the doctor who thinks stupidly that a nurse is a glorified nurse-maid, but also from the doctor who observes carefully, thinks clearly and sympathizes fully with the problems of nursing instruction.

The Part the Doctor Has Played

Against this it must be mentioned that the doctor is responsible for much of the emphasis on the theoretical. It is he who usually gives the lectures, sets the examinations and grades the papers. As a result, the instruction and demands often parallel those of medical students. If the result is a pseudo-physician instead of a capable nurse, he should be fair enough to share the responsibility. There are many nurses who as instructors in nursing schools are better able than are staff physicians to teach, from the standpoint of practical application of nursing, both the basic sciences and the clinical subjects of the nursing curriculum. The doctor also is responsible for the need for increased skill in nursing. Nursing procedures have increased in number and complexity not only because of the progress of medical science and the added facilities for diagnosis and treatment, but also because many duties formerly performed by the hospital physician or the hospital resident staff are now delegated by them to be done by nurses.

When it became evident many years ago that nursing meant more than maid's work, hospitals trained their students more carefully to care for patients and to carry out doctors' orders. Blood pressures and blood specimens, however, were not taken by nurses of even twenty years ago. Intravenous therapy was hardly known. These and many other procedures are now being transferred from medical care by doctors and interns to nursing care by nurses.

The routine duties of nursing, however, remain the same. The bed and the bedpan, the back care and the breakfast tray are identical with those of

yesterday. How much time is consumed by such duties? Estimates range from 50 per cent to 80 per cent. The fantastic fiddle-faddle which frequently flavors the parlance of nursing education tends to confuse and smacks too much of humbuggery and pseudo science. Let us profit by the mistakes of some other branches of education and avoid the development of a jargon which might require the assistance of both Einstein and the Supreme Court to interpret the procedure of punching a pillow.

It is noted that nursing has developed "habits of critical inquiry" in the care of patients. This principle is sound if directed to improvement in the nursing care of the patient. It has been fostered in other fields of training and unconsciously all educational activities become tinged with the idea of "keeping up with the Joneses." The duty of the nurse, however, is still that of making the patient comfortable. The care of the patient is nursing. The cure of the patient is mainly the practice of medicine.

Many hospitals are fearful of a shortage of both student and graduate nurses, a fear well grounded. In many sections of the country, a shortage already exists. The prosperity, real or artificial, which has accompanied the New Deal policy of spending billions of borrowed money and its reflection in increased private duty nursing are not the only reasons for the shortage. Neither can the shortage be attributed alone to the increased use of nurses in public health by government agencies, although it is perturbing to learn that twenty years ago, there were in the United States 5,000 public health nurses, whereas there are now 15,000 and that 50,000 are needed. Instances have been reported of clever propaganda directed to high school students to discourage them from entering nursing schools. Persistent pleas have been made to reduce their enrollment and there has been a decrease in the number of students in nursing schools. The glamor of the Great War is fading and such productions as "Men in White" do not continue to stimulate a surge of interest in a nursing career.

Not an Alarmist View

One need not be an alarmist to be concerned over the present and the future of institutional nursing. In an article which appeared recently in a hospital journal, the executive secretary of a national organization of nurses declared that "it is encouraging to find that fewer nurses are being graduated." An added comment was, "It is to be hoped that the good schools will not grow smaller in order to keep a balance between supply and demand."

There is a tendency on the part of nursing organizations to approach this problem from the standpoint of the individual nurse. This is no doubt a natural one, but the hospitals and the medical profession must think first of the adequate care of the sick. The closing of many small schools is justified if facilities for proper instruction are not available. The meeting of adequate standards in some instances made their training schools a financial liability. If the present trend for still higher standards and increased restrictions continues, the same effect may result in the larger institutions. Good nursing schools may be an economic asset even when the educational responsibility is realized, but red ink can only be used to a reasonable extent on the hospital ledger.

\$815 a Year to Educate a Nurse

The director of a well known hospital in the central states has computed the cost of educating a student nurse at \$815 a year or \$2,445 for three years. If this amount were charged to the student and if she were allowed 25 cents an hour for services rendered to patients in the first year, 30 cents an hour during the second year and 40 cents an hour during the third year, this charge for tuition and maintenance would be reduced to a net cost of \$1,330 for the three years. This might be compared with the cost of three years in an academic course in college. The analysis might also serve to refute the charge of commercial exploitation. If anyone is skeptical of the fairness of comparison with an arts and science course in an average college, let him consider the ease with which credits can be obtained for an A.B. degree. We have yet to put "Appreciation of Art" or "Ping Pong" in the nursing curriculum. Indeed, most R.N. diplomas imply more education than many a Ph.D. degree, awarded for such a thesis as "A Study of the Methods of Milking" or "The Love Life of the Louse."

These questions are frequently asked: "Why do hospitals assume the responsibility of training nurses? Why not let the state or private endowment take over the task as is done in other fields of education?" Hospitals have conducted schools of nursing because no other facilities for nursing instruction were available. They will continue to do so unless curricular and other requirements make it economically impossible or until government accepts the burden. The statement has been made that nursing instruction should be separated from nursing service. This hardly seems feasible but hospitals might be glad, indeed, to be relieved of the burden of training nurses and to be able to confine their interests to nursing service. It might well be said, "Take nursing education if you will

and make the most of it, remembering, if you please, that the gauge of your success will be, not the beauty of your theory, but the practicability of your plans."

The need for executives, instructors and other leaders in nursing is apparent. At least two prominent university or graduate schools of nursing have been established and a number of hospitals by university affiliation, offer a combined or degree course. From such sources, we expect to obtain our nursing generals. Where shall we recruit our nursing soldiers? Already many institutions are being forced to increase the sub-nursing groups and nursing attendants are being trained to do many tasks which formerly fell to nursing. The Horner Report of New York State recommended such a development. When confronted with a choice of no nurses or ordinary nurses, the hospital's decision is obvious.

In 1929 there were 1,885 schools of nursing accredited by state boards, while in 1935 there were 1,472, a decrease of 22 per cent. There were 17,000 fewer students in accredited schools in 1934 than there were in 1932 and 3,000 less are being graduated from schools of nursing than in 1932. The commissioner of hospitals of New York City said that the student registration in his department has so dwindled that today there are only 660 undergraduate students enrolled in six schools among the twenty-four department hospitals having a total bed capacity of nearly 16,000.

Do We Want a Brain Trust?

What are the real objectives of nursing? Are we to raise standards of admission to training schools to obtain fewer nurses who know more? Who then will do the routine duties of nursing? The professoriat may have taken Washington, but there is still some doubt of the desirability of surrendering bedside nursing to a brain trust.

In industry we have mechanical engineers and we have mechanics. Perhaps in health, we should have a nursing profession and a nursing craft. The latter, however, implies recognition, certification and licensure of both. Already many hospitals are using nursing attendants and more and more the duties formerly performed by nurses are being delegated to this comparatively new class of personnel.

Hospitals do not wish to exploit nurses. Moreover, hospitals recognize the potentialities of political pressure by organized groups. They also are sympathetic to the desire of nurses to fit themselves better for the work of nursing. The plea which is made is merely for moderation.

¹Read at the meeting of the New York State Hospital Association, Buffalo, N. Y., May 21, 1936.



Literature Climbs to Rooftop

DONE in soft colors, ranging in scope from cream to dark brown, the newly completed medical library at Ravenswood Hospital is restful and inviting, with its treetop view of the distant skyline of Chicago's loop and its comfortable chairs.

The addition was constructed on the roof of the hospital building, adjoining the solarium, at a cost of \$5,200, all of which was subscribed for the purpose by members of the medical staff and of the board of trustees. It is 15 feet wide and 50 feet long, with bookshelves lining all four walls. These are stained a dark walnut. The upper half of two sides of the room is given over entirely to windows, at which tan colored venetian blinds and drapes carrying the room's predominant colors are hung.

No table or floor lamps are in use in the room, the library being lit entirely through indirect ceiling lights. At each end of the room is an informal grouping of armchairs and occasional chairs upholstered in brown leather. A den-like effect is

further acquired in these groups through the skillful use of end tables, ashtrays and plants. The center of the room is occupied by reading tables, each accommodating four persons.

Formal dedication of the addition took place under the direction of J. Dewey Lutes, the hospital's superintendent, on June 25. Dr. Malcolm T. MacEachern, director of hospital activities for the American College of Surgeons, gave the dedicatory address and the student nurses' glee club sang. The community's civic organizations were guests of the institution on that evening. The following Saturday afternoon Margaret Simmons, the librarian, held open house for the medical and hospital libraries of the city.

At the present time the library owns 3,000 volumes and subscribes to 100 current periodicals, but the room has been planned to accommodate 1,000 additional volumes. The old library room is now a stackroom where back numbers of unbound periodicals, duplicates and the hospital's clinical records are filed.

"Sugar Bowls on Thursday"

By ELLEN E. STANDING

Superintendent, Sunnyside Sanatorium, Ottumwa, Iowa

FOR fifteen years our little hospital had marked its trays by the sugar bowl method. For a time the plain white labels were printed with pen and ink, then by hunt and hit of an old Oliver and finally by a noiseless Underwood manned by a modern, efficient typist.

True, there had been one innovation. There had been the year we invested in silver plated tray markers, ten of them, and the tray markers carried neat, white cards. But the silver plated tray markers went out almost as soon as they came in for their use entailed writing the name twice instead of once since the sugar bowl had to be marked anyway. Besides, the tray marker took up the four square inch of leisure space needed to give greater dignity to salad plate or glass of milk. Writing a name twice instead of once takes time. Placing two articles on a tray instead of one takes time. (So does taking them off.)

Almost a Sacred Rite

So back we went to the exclusive mark of the sugar bowl and for fifteen years little white labels on our sugar bowls identified our trays. For fifteen years, too, these little white labels were changed every Thursday morning. The work schedules were made out that way and work schedules were followed.

Work schedules are important things in a hospital—even in a tuberculosis hospital. More and more the tuberculosis hospital is acquiring the administrative standard of the general hospital. And so it should, providing, however, that it maintains and develops that unique psychologic quality so peculiarly essential to the success of a hospital treating a chronic disease. But to any hospital of this country—special or general—schedules are an important constituent of institutional efficiency. They are vehicles of accomplishment.

It may be a national characteristic of the people of "the States" to require concrete working plans—rails of steel on which the wheels of commerce or administration may more deftly glide.

Schedules are essential. It is wise to be well organized. Yet Miss Standing would have us remember that tradition may be a snare and, so remembering, ask ourselves sometimes "Is there perhaps a better way?"

Such may, however, be a necessary imposition because we lack a certain innate quality of thoroughness—a degree of that quality which Galsworthy's cobbler put into the making of his shoes.

A number of years ago it was necessary on account of growing pains for our hospital to make a definite change in its organization. A new department head had to be appointed. Feeling very young and being a true daughter of "the States," I was much disturbed about the lines bounding her department. "Just which tasks should be delegated to her?" I kept asking myself. "Just where should our responsibilities dovetail?"

Seeking council, I appealed to a friend who had for many years been an exceptionally fine and successful administrator of a tuberculosis hospital in Canada. He scolded me a little for my concern. "Working out such a scheme would be about the last thing I would try to do," said he. "Instead, work well in the middle of the field, cut big wide swaths where the grain is thickest and heaviest and do not worry about the straggling heads along the boundary." Then he offered some priceless advice regarding qualities and ideals of service and enthusiasm, advice which more than once has been a refining flame when organization lines tended to overshadow the objective.

Yet in spite of changes through the years, certain of our plans and schedules were left untouched. New departments were developed, by-laws were revised, the medical staff was reorganized, an out-patient department flourished, building expansions occurred, educational projects were introduced—chest surgery, experi-

ments in occupational and vocational therapy—yet through it all for fifteen years sugar bowl labels were changed every Thursday morning. Years ago the schedules were made out that way and the work schedules were followed.

Important things—work schedules! They are to an institution what subconscious actions are to an individual. They save time and brain power and act as a safeguard against sins of omission. "Sugar bowls on Thursday" offered a measure of security against sugar bowls being overlooked. And in an efficient hospital no details must be overlooked, not even dripping faucets or cockroaches or conservation of bread crusts or sales tax exemptions or squeaky door hinges or pneumothorax refills or soiled tray markers. One spring we forgot to trim the grape vines during the proper month. That year our grapes were small. Consequently we did not have so much grape juice to can as usual. Consequently, too, we had to buy some before the next season and all because we forgot to trim the vines. So to our list of schedules we added a seasonal work program for the grounds and included the trimming of grapes in February lest again we should forget. Yes, schedules are important.

Then came a Thursday morning that seemed unusually busy. There was confusion everywhere. Everyone about the place looked harassed because nothing was being completed on time. The maids were behind schedule with the dishes and because breakfast dishes were so late noon trays were detained. "It's all on account of the sugar bowls" was the plea. "We've so many trays now we can't possibly get through on time Thursday mornings. It's like this every week." Then a new voice piped in—a voice that had been in the organization only a few weeks—a young voice—"Why do we have to change the sugar bowls Thursday

morning? Why not in the afternoon when we have more time?" Why not, indeed! Just because for fifteen years this had been done Thursday morning was no good reason for continuing to do so for the next fifteen. So a change was made in the schedule.

To some this may seem a trivial incident but in the life of our hospital it was a significant event. Tradition had been challenged and was found deficient. We had been alert and yet asleep. Suddenly the lethargy of fifteen years was disturbed. If sugar bowls, why not other things? This occurrence, trivial though it may seem, marked the opening of an eventful year. Collections were good. An expansion project was launched and completed. Many valuable donations were received, including modern moving picture equipment. Other good things came to our hospital that year not entirely on account of this one incident but at least influenced by it. Standards are valuable things to have. It is wise to be well organized. Schedules are essential. Tradition helps maintain discipline, morale. But it is well, too, to listen now and then to the young voice within ourselves—the voice of honesty and candor questioning "Is there a better way?" Sometimes, too, by looking we see a better way and accept it.

A short time ago at a hospital meeting an excellent paper was presented suggesting some constructive ideals of economics. Following the paper comments of doubt filtered through the group of attentive listeners. "Sounds good but it can't be done," said some. "It would never go over in our hospital." "We've done it this other way too long to make any change now." Overhearing the comments I inwardly blushed remembering our fifteen years of "Sugar Bowls on Thursday."

Satisfactory Anesthesia Records

Many anesthesia records are valueless because details are not recorded. The International Anesthesia Research Society chart is simple and concise and unless the hospital is prepared to put in a supply of several thousand charts is as cheap as can be procured, in the opinion of Dr. John A. Hayward of the department of anesthesia, Homeopathic Hospital, Providence, R. I.

The blood pressure and pulse rate should be taken and recorded before the anesthesia is started, Doctor Hayward explains. After induction the blood pressure, pulse rate and rate of respiration should be taken and recorded every five minutes during the operation and more frequently when indicated.

On the chart should be noted the time induction was started, the time the operation was started and completed

and the time the anesthetic was stopped. The time required for the operation and the length of time the anesthetic was administered should be conspicuously placed on the chart.

The record of the blood pressure, pulse rate and rate of respiration gives a picture of what is going on. Impending shock is often shown by the blood pressure and pulse rate curves, and appropriate measures may be taken to avoid shock.

It is hardly feasible to keep charts for tonsil operations and certain dental and accident cases, Doctor Hayward believes. Nevertheless some anesthesia notes should be made in every patient's record and any untoward circumstance duly recorded. In major operations the conditions associated with recovery from the anesthetic should be noted, such as return of consciousness, nausea and vomiting and postoperative shock.

What Is an Eleemosynary Charter?

BROADLY defined an eleemosynary charter is granted by the legally constituted authority, the state, to a group of individuals, an association or society who wish to incorporate for any lawful purpose other than for pecuniary profit.

The requirements for, and restrictions on, eleemosynary charters differ in the various states but generally speaking there exists wide latitude of discretion in the granting of these not for profit charters. Religious institutions and schools, educational institutions, libraries, hospitals, clinics and other public health institutions, organizations and institutions for social welfare, and many others whose social usefulness might be questioned are legally eligible for the privilege of the eleemosynary charter.

Considering the broadness of the subject, the varying laws and above all the divergence of public opinion created by time and place and more especially by personal factors and viewpoints, one would indeed be rash dogmatically to propose standards of eligibility for the not for profit charter. We may with profit, however, consider some of the salient features involved.

Three Salient Features

The eleemosynary charter, as it incorporates the activities of social institutions in our country, to me conjures up three important points for discussion — first, the privileges which it bestows on the incorporating group, second, the reciprocal responsibilities the association must assume and third, the abuses to which not for profit charters are open. All privileges, even wise ones, are sometimes abused.

The eleemosynary charter is a great legal contribution to modern society in that it is one of the greatest imaginable boons to the organization of charitable, philanthropic, altruistic and general social activity. But unless abuse, both in issue of the charter and in activities incorporated by it, is curtailed, many necessary social activities are going to suffer seriously by reason of adverse popular reaction to, and legislative attack on, all organizations and institutions operating under such not for profit charters.

A consideration of its privileges, its responsibilities and its abuses

By REV. JOHN W. BARRETT

Diocesan Director of Catholic Hospitals, Chicago

Religious, educational, public health and philanthropic organizations operating under not for profit charters are granted numerous benefits not allowed to corporate or individual commercial enterprises. The immediate and perhaps the greatest privilege granted institutions incorporated under the eleemosynary charter is their freedom from taxation. This exemption from taxation differs in the various states. In some states freedom from taxation extends even to properties owned and operated by the eleemosynary institution whether or not the properties are used directly for the defined purposes of the institution. In Illinois, property, the income of which is applied to defined activities of the social institution, but upon which the social institution is not located, has been held subject to taxation. Certain states, including Illinois, specify that only property not leased or otherwise used with a view to profit should be exempt from taxation.

In Vermont the eleemosynary institution forfeits to the state all property held in excess of \$10,000,000. In Massachusetts this amount is reduced to \$2,000,000. South Dakota is indefinite, ruling that no charitable or religious corporation shall own more property than may be reasonably necessary for its purposes.

If we would have an example of legislative attack on the not for profit charter we need but look at the Mississippi law which holds that every bequest for charitable or religious purposes is void. While I am sure all of us have a broad social consciousness our main concern is the hospital, the clinic and public health work. We know how consistently the federal government has refused to use relief money for the care of the indigent sick in voluntary hospitals. We know the energies that were expended to secure certain exemptions

from the multiple taxation created during the past few years. We know the difficulties encountered in securing exemption from legislation inimical to the stability of institutions. May we not seek the cause for all this in an increasingly adverse public opinion with regard to voluntary hospitals.

While freedom from taxation is perhaps the most immediate and eloquent contribution by the state to institutions incorporated under the eleemosynary charter there are many others no less important. The scope of activities, social and otherwise, in which an eleemosynary institution may engage are very broad — perhaps in some instances too broad to safeguard public interest. In most cases, however, this freedom in scope of activity is wise and necessary.

Another notable privilege enjoyed by not for profit institutions is their comparative freedom from state or federal supervision of their fiscal policies and financial features of operation. But perhaps the greatest practical privilege such institutions enjoy is the fact that with usually only minor, if any, restrictions, they may appeal to the public for funds without making any specific statements about, or guarantee of, uses to which the funds will be put. In addition state and federal governments have put a premium on giving to institutions operating under eleemosynary charters by making a reduction in the income taxes of those contributing to such organizations.

These and numerous other privileges are for the most part good, although in their application they are sometimes careless, to say the least, of public welfare. Far be it from me to advocate government supervision of eleemosynary institutions or anything that savors of it. I subscribe thoroughly to the principle that the indigent and underprivileged are the wards of society and not of the state. The state, however, in granting the eleemosynary charter creates a legal entity; it is, therefore, the state's business to grant it intelligently, and in the cases where there may be detriment to public interest and the common good, to keep a judicious eye on the scope and kind of activity permitted under the not for profit charter.

Responsibilities Under the Charter

The unusual privileges under an eleemosynary charter cannot be granted to an association or organization which will not accept reciprocal responsibilities. If social institutions are given unusual privileges they should assume full responsibility and employ scrupulous care in the exercise of their prerogatives. The law does not require a great deal from social institutions and there is a minimum of supervision and regulation

of their activities. Under such circumstances any restraint, acceptance of responsibility, and ethical action in general, must be self-imposed.

Service rendered the public or some section of the public is obviously the first consideration of responsibility under the eleemosynary charter. Social utility of the institution or the organization is the most important thing. The social value of an institution might offer matter for controversy. If it does it is not my intention to open such controversy here. Religious institutions, educational institutions, philanthropic and welfare organizations and last but not least hospitals, clinics and public health institutions are all performing work about which there is no particular controversy as to social utility. And yet even among these are numbered some which, under careful scrutiny, would show an abuse of prerogative and failure in their acceptance of responsibility.

Scope of Service

Going further in our discussion of the responsibility of eleemosynary institutions, the scope of their service must be taken into consideration. Here there is a fine line between the limits on volume of service rendered and the limits imposed by other considerations which make the service discriminatory. Basically no truly public-spirited institution can discriminate against the racial, religious, political, social status of those it serves.

Where discrimination begins to enter in the service of an institution is sometimes hard to define. Perhaps some examples will illustrate the point. Let us say that in a densely populated area, a small hospital of 100 beds is opened for the care of obstetric cases of Catholic women and that no other cases are accepted. There is obviously a restriction of service; first, it is restricted to obstetric cases and, second, it is restricted to patients of the Catholic religion.

Is such service discriminatory in actual fact? If we analyze the situation it becomes clear that it is not. In the first place a hospital of 100 beds could not handle all the cases that would ordinarily be given general hospitalization in any large and densely populated area and secondly the restriction to obstetric cases is a matter of efficient management. It is one institution among many and merely chooses to specialize in one type of case. It does not discriminate against accident cases because it is fair to assume that there are other hospitals in the area which would properly care for such cases. In other words the hospital is so small compared to the needs that we have only restriction, not discrimination.

With regard to the second point, namely, that the hospital accepts only Catholic women. Here

again, the number of Catholic women whom the hospital is able to serve is so small a part of the total community that it could not be presumed that the hospital should serve all obstetric cases. Again, restriction to a specific group is only a matter of efficient organization and is not discrimination. On the other hand if all the beds in all the obstetric hospitals in the community were restricted to Catholic women, or if Catholic women were given preference of admission to all the obstetric beds in the community we should have not only restriction but discrimination. Our sample hospital presumes fairly that there are many hospitals in the community where the medical, surgical and obstetric cases that it does not accept may receive adequate hospitalization.

We should not assume, however, that actual discrimination may not be observed in the rendering of social service. An example of such discrimination might be found if in a stipulated area the major portion of public or community funds were put into welfare work for those of the Catholic faith. We have discrimination here because the organizations charged with responsibility for social service in a given service area have produced an unbalanced situation which is in actual fact discriminatory against those who do not profess Catholic belief.

When Discrimination Enters In

It becomes plain, then, that possible discrimination against certain groups must always be judged on two bases. First, there must be a stipulation of the service area involved and second, there must be a stipulation of the section of the public which will be served. If these stipulations show an unbalanced condition in the provision of social service, then discrimination exists in fact, whether it is intended or not. Institutions practicing such discriminations are unworthy of the privileges granted by the eleemosynary charter.

Another unquestioned obligation of an institution operating under a not for profit charter is that of exercising scrupulous care that no one profits abnormally by the operation of the institution. This means, of course, that all salaries of employees must be as nearly normal as possible. It is possible to set up an organization under an eleemosynary charter, solicit funds for a specific purpose and then pay such abnormally large salaries that individuals administering the organization would in effect be operating what is termed in the vernacular "a racket."

There are unfortunately such rackets in operation under not for profit charters and it goes without saying that adverse public reaction to these is tremendously unfair to the hundreds of ele-

mosynary institutions in which the personnel and administrative forces are not paid normal salaries for their work. Further, the fact that institutions operating under eleemosynary charters are not subject to stringent accounting and reporting laws makes it imperative that institutions that desire to discharge their full responsibility be conservative in their accounting and financial operations.

Abuses of the Charter

The major abuses of the not for profit charter have been brought to light in this discussion thus far. Other possibilities for abuse are found in the fact that under our present system it is possible to secure an eleemosynary charter for anti-social activity, and paradoxically, eleemosynary charters are granted even to organizations that are subversive of public interest rather than socially useful. Frequently the purposes of the institution are so generally stated that no proper definition of their service is possible. It seems no more than logical, then, to require that the purposes of eleemosynary institutions be more specifically defined.

That there is adverse public reaction to some institutions operating under eleemosynary charters I think no one will deny and unfortunately such reaction is justified. This adverse reaction is manifested in legislative attack on all eleemosynary institutions and is characterized most generally by an attempt to assess taxes against such institutions, taxes which would frequently be unbearable.

Effort should be made to amend the laws under which eleemosynary charters are granted so that unworthy institutions may be denied the unusual privileges granted by such charters. These efforts must come from those who are conscious of the situation and they must be organized. Otherwise, we face adverse reaction both in public opinion and in our legislative assemblies.¹

¹Read at the meeting of the Tri-State Hospital Assembly, Chicago, May 6 to 8, 1936.

Campaigning Against Noise

A large metropolitan center recently instituted an intensive campaign to reduce noise throughout the city. Capitalizing on the situation, a hospital in that city made a concerted drive for the elimination of unnecessary noise in its own immediate surroundings. The architectural layout of this hospital is such that a court, in which much of the activity incident to the operation of the hospital converges, is flanked by hospital buildings on three sides. To eliminate noise in this area, three large "Quiet" signs were so placed in the court as to be readily seen from any angle. Letters were sent to tradespeople, delivering to the hospital, asking their cooperation. The resulting noise reduction was immediate and of gratifying proportion.



A new era for Huntington Hospital, Huntington, Long Island, centers upon the fact that it possesses friendly doors, through which the visitor passes into a cool, inviting reception hall.

BUSY days in Huntington, Long Island—days which mark a new era of hospitalization for that community. They started a little less than three years ago when the public was invited to attend the opening of a brand new seventy-five-bed hospital. They continued through the uncertain period of infancy into perplexing adolescence. The end is not in sight, but already discernible is the outline of a modern community medical center. After all, time does march on.

Even before that day in November, 1933, when the doors of the new building were thrown open, Huntington had its hospital of thirty-five beds with every inch of space taxed to capacity. Becoming more retrospective, in 1916, when first organized, it boasted eighteen beds for adults, four beds for children and six bassinets.

In those days, however, little attention was given to friendly doors. While aware of the pres-

Hospital Days at H

By RAYMOND P. SLOAN

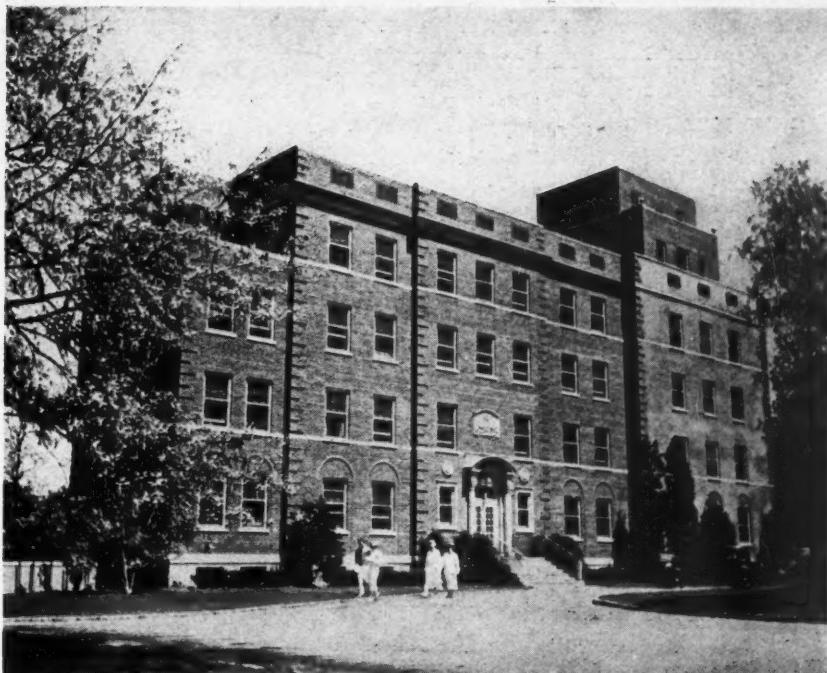
ence of the inconspicuous little building standing on wooded property just outside the town, only those threatened by dire emergencies ever actually knew what went on within. The hospital was of the community, yet strangely apart from it. The story begins, therefore, when events began to shape themselves and Huntington Hospital emerged from obscurity with a modern brick building of fireproof construction, costing \$206,539.39 and containing equipment valued at \$38,122.37.

The modern building is not the entire story, however. Accompanying it are accomplishments in thoroughly revised organization and new executive management embodying very different ideas about the relationship which should exist between the hospital and the community it serves.

From the start this hospital has had a rare advantage over many similar community institutions in enjoying a close contact with the local chamber of commerce. In fact the new building project and reorganization came under the direct control of that body. Its secretary is secretary-treasurer of the hospital.

The importance of this tie-up, when fully recognized, was responsible for the introduction of a wholly new attitude on the part of the organization toward the community, and in turn on the part of the community toward the hospital. It marked the start of a program of education in which the residents of Huntington Township, some 25,852 in all, are being made hospital conscious. Even such retarding influences as the withdrawal of the superintendent to private life, after two years

Huntington



spent in laying the groundwork, failed to leave any appreciable mark. The assignment of Mary Jane Hutchinson to the post last January has lent renewed impetus to the work of cultivating public interest and support.

First indication of the new era to reach residents of Huntington was the appearance on the bulletin boards of public buildings of announcements of monthly meetings scheduled to take place at the hospital. In addition, a cordial invitation to be present was extended them by clergymen of the various churches in town, whose cooperation had already been enlisted.

That first meeting will long be remembered by the hospital organization. A member of the Associated Hospital Service of New York had been invited to speak on group hospitalization. By the time the hour had arrived a substantial audience had gathered, many of whom never before had put foot inside the building. The success of the experiment was assured from the very start.

To appeal particularly to members of the parent-teacher association as well as to teachers in the local schools, a representative from the National Education Association was placed on one of these programs. On another occasion a member of the staff of Carnegie Institute in Cold Spring Harbor delivered a talk on leukemia in relation to the growth of tumors. Believing this to be of special interest to women, an invitation was extended to the 400 members of the women's auxiliary.

Then came National Hospital Day, a fitting climax to the series of health talks. Throughout

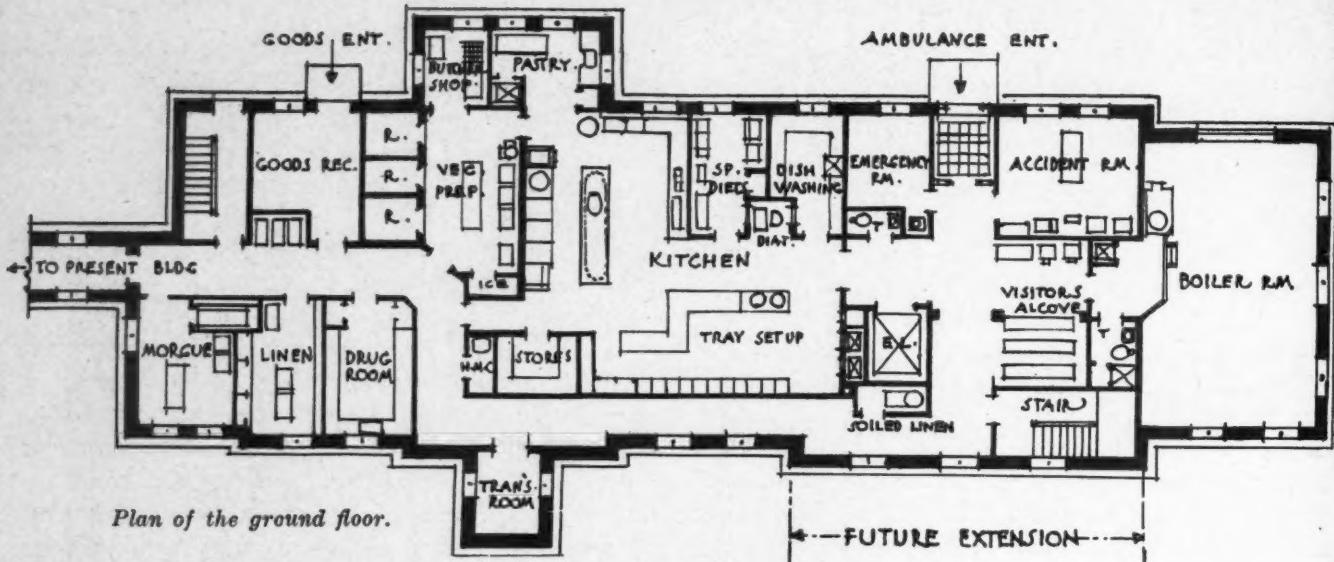


Bright flowered prints on the walls add an attractive touch of color to the cheerful reception hall.

the hospital exhibits were established, with emphasis on those phases of the work which it was felt would have the most appeal. The roentgenologist set up films in his viewing box for the benefit of the visitors. In the obstetric department attention was focused on the methods employed in identifying infants. Probably no exhibit aroused quite the same amount of attention as that illustrating the process involved in performing blood transfusions. Each department had something to show of interest to the public.

Only the approach of summer brought an end to the series of meetings. Steadily mounting interest, as evidenced by the larger audiences attending each successive event, made it apparent that the idea must be developed further. Already plans are under way for a more elaborate program next winter.

During these months when the public was being



Plan of the ground floor.

invited to enter the hospital through its friendly doors, the cooperation and support of specific groups was likewise sought. As guest of honor at one of the regular weekly meetings of the Rotary Club, Miss Hutchinson had the opportunity of describing the reasons for hospital costs. The revealing facts she had assembled gave the business men of the community a new insight into the problems of hospital administration.

A message from the hospital was also carried into the schools in connection with the Vocational Guidance Council. One day this spring its superintendent was invited to talk to those students interested in nursing.

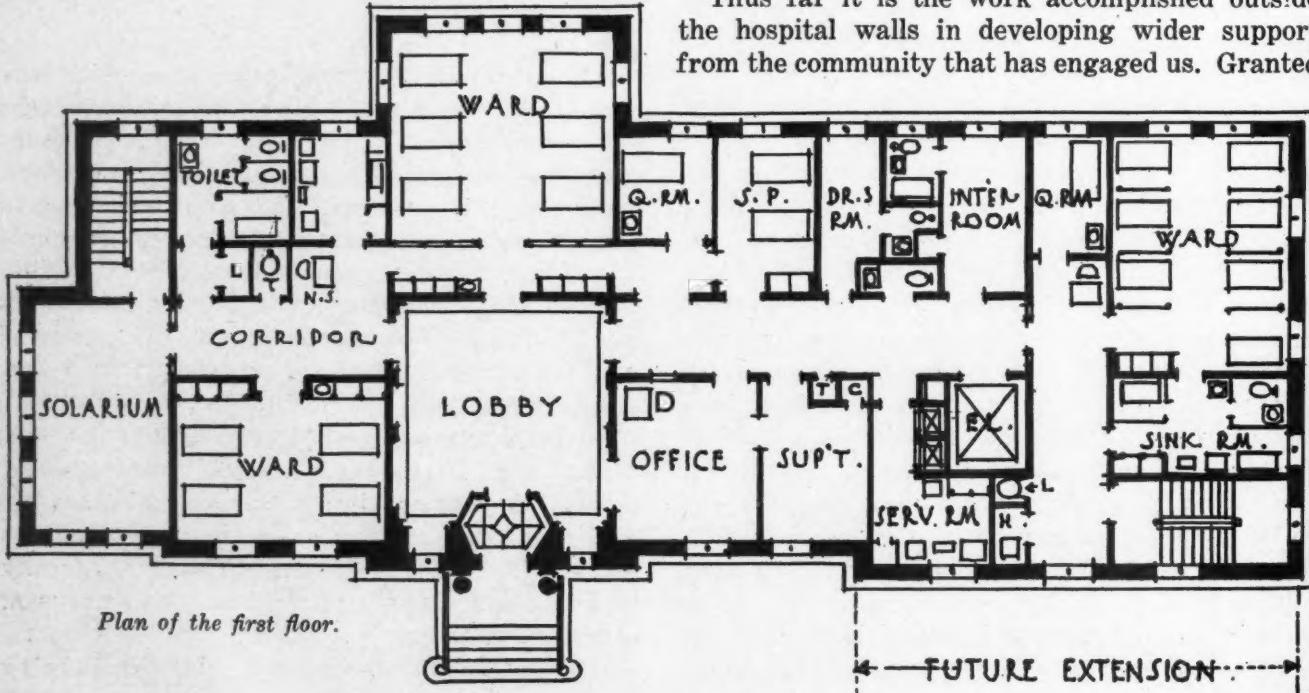
A particularly significant event took place at the hospital during last winter when the Republican Club gathered to inspect the building and learn more about the various services it renders. It is not often that a superintendent has the op-

portunity of entertaining a political group. Again Miss Hutchinson was able to present certain salient facts about modern hospitalization.

Much of this public relations program has centered about the women's auxiliary. Frequently when members gather at the hospital for their regular monthly meetings, they are informed of some specific phase of the work with which they have not heretofore been brought in contact.

Much can be accomplished, it has been found, by establishing a closer relationship with all the churches in the community. Reference has already been made to the announcement of the monthly hospital meetings by pastors from their pulpits. On more than one occasion a clergyman has been found exceedingly helpful in securing payment of a back bill. It has been discovered also that a patient will confide in his pastor about grievances, he would not speak of to the administrator.

Thus far it is the work accomplished outside the hospital walls in developing wider support from the community that has engaged us. Granted



Plan of the first floor.

success in this public relations program, there still remains the question of what happens when the visitor finally crosses the threshold. What are his reactions; how is he received?

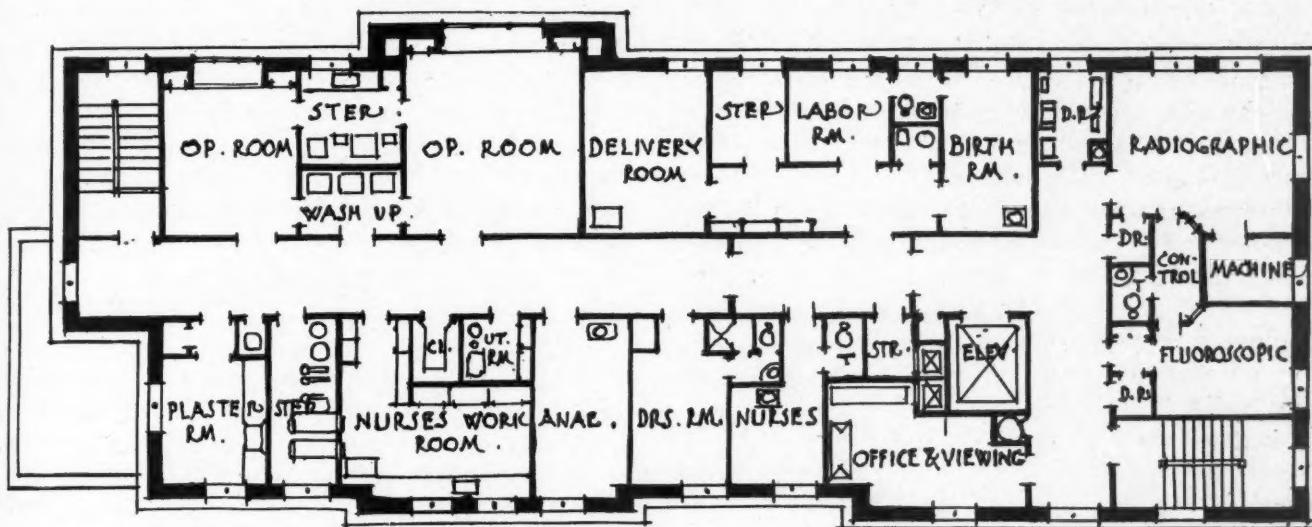
As part of the plan to inaugurate a new era for Huntington Hospital, attention was deliberately focused upon the fact that it possesses friendly doors, a point about which some question had been raised in its earlier days. Excellent material with which to work was provided by the architects, Crow, Lewis & Wick, who were responsible for the design, along with Dr. S. S. Goldwater.

If ever a doorway was designed to be friendly, it is that at Huntington. Through its shining glass windows the visitor catches a glimpse of a lounge and reception hall, clean, cool and inviting. Only the desk to the right belies the effect of a spacious hallway in a private country home. Outdoors is

laboratories are the best obtainable. Here is my x-ray department or that small part of it which could be shown in a small picture. This department comes in for maximum use in my new home by reason of the great number of accident cases admitted here."

This extraordinary little mailing piece carried its message into homes and made many new friends. Never before had any attempt been made to explain the purpose of the hospital in this way. For sheer originality, in fact, it stands unique in hospital literature. The simplicity with which the story is recounted and the atmosphere of friendliness it creates recommend it to the attention of every hospital administrator and trustee.

More than an attractive entrance is necessary, however, to make the visitor feel at home. What good is the most pretentious physical layout, if



The fourth floor at the top of the building comprises operating suites, delivery rooms and a nurse's workroom.

brought inside through prints of bright bouquets on the walls, and soft leaf-green upholstery.

So it transpired that the directors of the hospital, the entire staff and organization became vitally concerned about these friendly doors, and determined that they should be thrown open to the hitherto unsuspecting public. It could not be expected, however, that any large number would open them physically and inspect the wonders that lay beyond. So instead, the doors were brought to them in the form of an attractive little booklet, which they might open and learn therein all about the new hospital and its service.

Inside the front cover the hospital greets the reader personally and escorts him through the entire institution while explaining its many functions. Just one quotation will serve as an illustration: "I would find it difficult if not impossible to choose a single department of my new home for special emphasis. Yet it has already been said that my guiding stars of the x-ray and pathologic

the warmth of sympathetic human contact is lacking?

It is unfortunate, perhaps, that so much depends upon the actions and response of unskilled labor in hospitals—the maids, porters, cleaning women. Yet, properly trained to the realization that they and everyone else who comes in direct contact with the public has a real contribution to make, it is surprising what important rôles they can play in developing goodwill. A reassuring smile from the attendant polishing the handle of the front door will accomplish wonders in establishing it in the visitor's mind as a friendly doorway—one whose threshold he actually likes to cross. And a welcome from the maid who happens to be dusting the room as the patient enters will help banish that forlorn feeling common to all who first enter an institution for medical care.

Maids and porters can actually do more than the superintendent in creating a friendly atmosphere, Miss Hutchinson firmly believes, for the

very reason that they come in closer contact with the patient. Therefore much time and effort have been spent in assuring the public service with a smile.

As advantageous as it is to have an attractive reception hall and entrance, its only excuse is to provide comfort for the patient and put him at ease. It fails of this purpose if he experiences embarrassment at being obliged to step up to the desk and make his business arrangements within earshot of others who may be waiting.

To assure complete protection and privacy a room across the hall from the entrance at Huntington is being used as an admitting office. This means temporarily sacrificing a two-bed semi-private room, it is true, but the two beds can be placed elsewhere; anyway, it must be made as easy for the patient as possible.

It is just as essential that the hospital check on each patient's financial standing and arrive at some definite agreement with him as to services and charges. Close supervision is maintained over all accounts in the new set-up at Huntington. Each morning the bookkeeper, who handles admissions, places on the superintendent's desk a form listing admissions for the day preceding and the basis on which they have been entered. This eliminates the possibility of any patient being in the house without some equitable arrangement being made for his stay. The superintendent likewise keeps constantly before her a record of all welfare patients.

Cost Per Cubic Foot

Having entered the publicized doors, admired the homelike surroundings, and been greeted with a smile of welcome by those in attendance, the visitor will want to make a complete tour of inspection of the entire building. Thoroughly modern in every respect, brick on steel frame, four stories in height, and with reenforced concrete floors, its entire layout is practical and lends itself to economical and efficient management. Furthermore, it has been built for expansion, making it possible to erect a wing on one end which will provide total accommodations for upwards of one hundred patients. At present provision is made for sixty-eight adult beds, seven cribs and sixteen bassinets. Huntington was fortunate in being able to launch its new program of hospitalization with an economical building. The period of the depression was well advanced when construction finally started. It was necessary to scale down considerably to meet existing exigencies. The cost per cubic foot without equipment was 53.1 cents; with equipment and fees included, 66.7 cents.

With the doors finally opened it became just as essential to operate the building economically. This is being accomplished chiefly by close supervision. Outside of the return from an endowment of \$160,000, such items as are donated by the women's auxiliary and small gifts, the hospital depends upon income from patients.

It is meeting its expenses and discounting its bills. This has been achieved by reducing all waste and exercising great care in purchasing. If a local merchant will offer and continue to provide quality products as low as can be procured in the metropolitan markets, the business is his. Otherwise the hospital deals elsewhere. Recently in the case of one commodity, a saving of \$100 in a month was effected by dealing directly with the wholesaler. Again it is necessary to keep close check on all prices to see they are maintained. Purchasing is based on the premise that it is best to order in large quantities and receive deliveries in small amounts or as designated. This makes unnecessary any large storage space.

Superintendent Plays Dual Rôle

As important as it is to economize, adequate personnel is essential to provide efficient service. The personnel of Huntington has been increased during recent months in line with a higher rate of occupancy. The superintendent likewise acts in the capacity of supervisor of nurses, thus keeping in close touch at all times with the nursing situation. The assistant superintendent also has charge of the delivery room.

The accompanying plans show the layout clearly. It will be noted in the drawing of the first floor that a ward runs along one end, embracing the entire corner, thus permitting an abundance of light and air. Another ward is placed directly at the rear of the entrance lobby. At such time as expansion takes place this will be diverted to office use, as was originally planned. An attractive solarium is provided at the opposite end of the building. All corridors throughout the building are treated for sound absorption, and rubber tiling is used on the floors.

Much the same layout is applied to the second and third floors.

Before heading again through the woods that surround the hospital, mention of the term "director" brings to light an interesting experiment that is now taking place. They will tell you at the hospital that it is frankly an experiment, but so far one that bears much promise. Officers rotate each year, the president, anyway. He is elected for a twelve-months' period only. This makes for a more active and interested group and provides a bit of competition that is stimulating.

Insuring Safety by Insurance

By V. L. DOUTHIT

Fire Protection Engineer, Chicago

IT SEEMS that the trend in hospital insurance is definitely toward comprehensive policies. Insurance companies realize the disadvantages of a hospital having one policy for fire insurance, another for windstorm, still another for explosion and so on, but the transfer from such policies to comprehensive ones is difficult to make for a variety of reasons and the change must be gradual and sure.

One step in that direction was taken not so long ago when a broad form property insurance policy was devised and offered in several localities. It is now available throughout the greater part of the country and no doubt soon will be everywhere. This policy gathers together into one basket, figuratively, a number of policies that were formerly available only separately, and, with a standard fire insurance policy as a basis, provides protection against the hazards not only of fire, but of windstorm, cyclone, tornado, hail, explosion, riot, civil commotion, aircraft damage, self-propelled vehicle damage and smoke damage.

Such a policy, ordinarily referred to as "supplemental contract," or "extended coverage," only a few years ago would have been considered almost revolutionary even among a group of insurance men, but is now in general use not only in hospital insurance but in most other classes, in spite of the fact that it is comparatively new.

Cost Not Excessive

Another almost revolutionary feature of this broad form of insurance is its cost. Formerly, under the plan of separate policies for each coverage the premium on each policy, although varying according to the probability of occurrence of the hazard insured against, was a considerable item in itself. Yet the premium on this new comprehensive policy is but little more than the cost of fire and windstorm and tornado insurance alone. The saving produced in preparing and recording one policy instead of several, undoubtedly accounts for a goodly portion of this saving in the cost of protection.

A review of this rather new and important step in insurance protection suggests a consideration of a few other forms of hospital insurance, in

fact, a consideration of this entire group of coverages generally referred to as fire insurance side lines, and unfortunately, sometimes relegated to the side lines. We have in mind windstorm insurance, supplemental contract, already discussed briefly, use and occupancy or business interruption insurance, steam boiler, automobile, rent and rental value insurance, radium insurance, physicians' and surgeons' instrument insurance and insurance providing indemnity for the hospital's liability to third parties—employees or the public.

Fire and windstorm insurance are in practically universal use. The fallacy in omitting windstorm insurance appears when one considers that the terms of a standard fire insurance policy provide no indemnity on a building already materially damaged by windstorm, even though fire may follow as a result. It is the purpose and intent of the windstorm and not the fire insurance policy to cover such resulting fire loss.

This same condition serves to illustrate the need for the coverage already described as "supplemental contract," since all of the hazards, except fire and lightning, insured against in that contract are beyond the scope of the fire policy, which by its terms no longer is in force after a material damage to the property insured has occurred by some cause other than fire. The fire policy is not an "All Risk" policy; its premium charge is sufficient to provide for fire and lightning loss or damage only.

The need for adequate automobile insurance is also quite well understood, and practically all hospitals insure automobiles owned by them. Such policies usually cover against fire, theft, collision,

Insurance policies may be as many and varied as hospital hazards but the wise institution will figuratively speaking gather all its policies into one basket under a broad form property insurance policy, as described here

public liability and property damage, all of which are important and no one of which should be omitted, if the property as well as the liability of the automobile owner is to be properly protected.

Business interruption insurance, more commonly known as use and occupancy, is designed to indemnify the hospital for loss of prospective earnings occasioned by the loss or damage of the building by fire or other hazard, necessitating an interruption of business. Properly written, it should do everything for the policyholder in the event of loss which the business would have done had no interruption occurred.

It is valuable not only to those hospitals operating for profit, but for all others as well, since it is possible to insure those prospective earnings which would be applied to expenses that would continue even though the business were interrupted, such as administrative salaries, taxes and interest on funded debt, as well as those that would be available for profit. The need for this protection may be rather strikingly illustrated if a list is made of those expenses that would necessarily continue if a hospital were prevented from operating because of property loss or damage, for although use and occupancy insurance does not insure expenses, it does insure anticipated earnings that are used to pay those expenses as well as profits.

What Rent Insurance Covers

Closely allied to use and occupancy is a form known as rent insurance. Rent insurance undertakes to continue ordinary rentals received by the hospital on property which it owns and rents to others when those rentals are stopped by the damage or destruction of the property.

Rental value insurance, a branch of rent insurance, provides the hospital with indemnity to offset the expense occasioned by renting another building because of the damage or destruction of the hospital owned and used by the institution. This latter contingency may of course be provided for in a use and occupancy policy, in which case a rental value policy would be unnecessary.

Steam boiler insurance may be had in a variety of forms depending upon the nature of the equipment and the extent of the coverage, the intent of such a policy being to indemnify the hospital for damage to its own property and the property damage liability claims of others resulting from the explosion or rupture of boilers and similar equipment. Probably as important as any other feature of boiler insurance is the excellent boiler inspection service that such a policy provides. This inspection service has been most effective in reducing and avoiding losses through finding de-

fective equipment so that repairs or replacements may be made before the damage occurs, a service of particular worth to the hospital.

With so great value confined to such small items, readily lost or misplaced, radium insurance is essential. Radium policies cover all risks, while the subject is contained within continental United States and Canada, except the loss or damage by gradual deterioration or that resulting from a repairing or restoration process, or a few other such standard policy restrictions. Such policies may be had for insuring radium in any form—tubes and plaques, needles or cells.

A similarly broad form of protection may be secured for physicians' and surgeons' scientific instruments and apparatus covering all risk of loss or damage during transportation or otherwise.

Forms of Liability Insurance

The possible claims for property damage or personal injury arising from the liability of the hospital to employees and the public are numerous and varied. Many of these risks of liability may and should be transferred to insuring companies, for the burden of liability claims is often severe enough to handicap seriously normal operation, if not to disrupt it entirely. The more common forms of this type of protection are: owners' landlords' and tenants' liability, covering the hospital's liability for damage suits resulting from accidental death to members of the public in and about the hospital premises; elevator liability, covering the hospital's liability for claims arising from elevator accidents; workmen's compensation or employers' liability; products liability, to cover any possible liability for alleged harmful results from purchases of drugs, merchandise, or food from the hospital; druggists' liability; malpractice insurance, to cover the widely varying forms of liability for claims arising through the alleged malpractice of the staff and employees, and automobile liability, covering property damage and personal injury claims resulting from the operation of automobiles owned by the hospital or owned by employees and operated in the interest of the hospital.

This should hardly be considered a complete list of hospital insurance, for the insurance needs of no two hospitals are exactly alike and some will be more or less unusual. The more generally used forms of hospital insurance have been mentioned, but the hospital administrator interested in providing complete protection will require, of course, more specific knowledge of these types of insurance as applied to his particular property. And for that purpose he will want to consult his regular insurance adviser.

A Layman Looks at a Hospital

As Told to

CHARLES F. NEERGAARD

Hospital Consultant, New York City

MISTAKES of planning and equipment in an old hospital are no news but in a new building they seem almost unforgivable.

This is a story told by a consulting engineer of some things he saw and wondered at. He said, "My daughter needed an operation. I took her to the newest hospital in the city, presumably the best. During my various visits I noticed so many details in the building which struck me as wrong that I made a list to ask you how such things could be. I am not competent to criticize a hospital but if the little errors in the small corner which I observed are typical of the whole institution, it must have cost a lot more to build than was necessary and certainly with more careful planning it might have been made far more

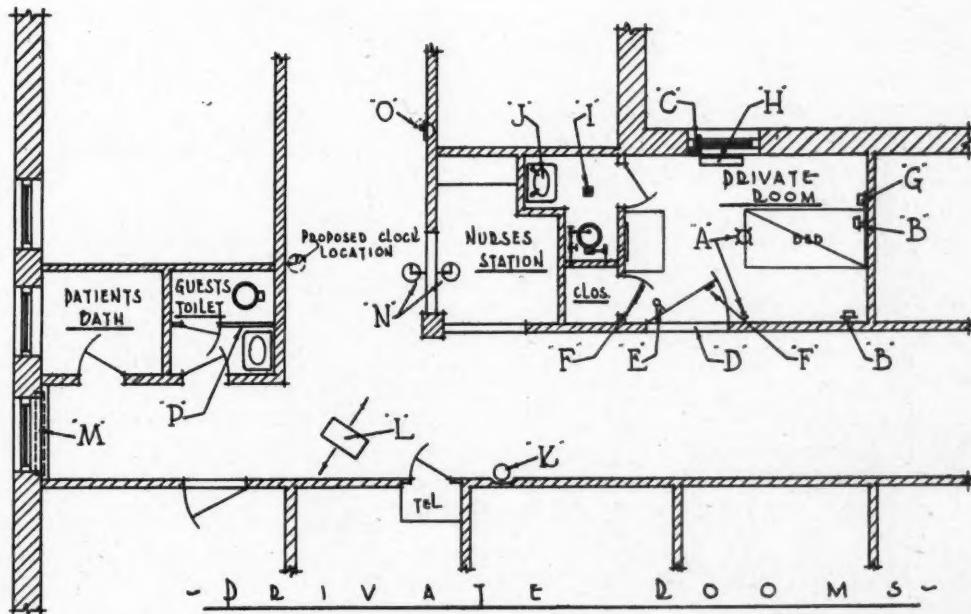
comfortable for the patient and convenient for the nurse."

One could not but agree with his conclusions. The drawing here reproduced was prepared to show this "Tragedy of Errors." The facts are his — some of the comments are mine.

In the small private room which his daughter occupied he noted:

A. A ceiling light fixture had been installed originally, but had been removed and the outlet and switch control capped. How many thousands of patients have been subjected to the torture of lying in bed with the glare of a ceiling light in their eyes. Why keep on doing it!

B. This left no light for the bureau and the only illumination was provided by a floor lamp and a bedside table light, connected to receptacles in



One little corner of the city's "Last Word."

the far end of the room, which had no switch control except at the lamp. While a night light was installed the control switch beside the door was so noisy that after the patient had been wakened two or three times through its use the nurse thought it advisable when she wanted a light at night, to tiptoe across the room, cover the floor lamp with a dark cloth and turn on the quieter socket switch.

C. A radio outlet for aerial and ground, obviously an afterthought, was attached to the window frame, poorly located and objectionable in appearance.

D. The sill of the door was raised half an inch above the floor, over which beds, stretchers and vacuum sweepers bumped when they were moved in or out.

E. The corridor door was controlled by an overhead door check which was a great nuisance to the nurses when they were carrying meal trays or flowers. The door had a noisy latch, with a rubber band from knob to knob to quiet it. If the door had been hung at the other side of the opening it would have shielded the bed and obviated the necessity of the movable screen, which was always in the way.

F. There were cylinder locks on both toilet and closet doors, which cost at least \$5. Are they ever used?

G. The telephone box projected from the wall and interfered with moving the bed.

H. An exposed radiator was almost double the size needed for so small a room, which was constantly overheated. The radiator valve extended above the window sill.

I. A private toilet opened off the room. There was a jet in the bottom of the toilet bowl for washing bedpans. This proved a noisy and disagreeable procedure. Unless the nurse closed the door when emptying the pan, which she often failed to do, the odors came into the room.

The control valve for the bedpan washer was at the bottom of the toilet bowl. Should this valve be open when the cold water riser happened to be empty, the contaminated water would syphon into the water supply.

The shut-off valve to the toilet was on the wrong side of the control valve. In many cities a vacuum breaker on flush valves is mandatory. It has long been considered essential in hospital practice. Here it was omitted.

The toilet room had no window and was connected with an exhaust ventilating duct but as there was no opening in the door to provide circulation the ventilation was ineffective.

J. The lavatory had separate lowdown hot and cold water faucets instead of a combination goose

neck faucet, from which basins and pitchers can be conveniently filled and under which hands can be washed in tempered running water.

In the adjoining corridors the following facts were noted:

The corridors were noisy and no acoustical treatment quieted voices and footfalls.

K. A recess was provided for the fire extinguisher but was so shallow that the tank projected 8 inches into the corridor.

L. A double face annunciator to call the doctors was placed on an angle at the intersection of the corridors, the inner side being visible only to a person standing with his back against the wall. A single face annunciator was all that was needed.

M. The corridor radiator was concealed. The extra money spent here might better have been used to conceal the radiator in the private room.

N. Two clocks were installed above the opening to the nurses' station, one on either side of the partition, where a single clock on the opposite wall would have sufficed.

O. The recess for the drinking fountain was so shallow that the fixture projected into the corridor.

P. The guest toilet had an expensive marble interior partition although the room was so small that it was usable by but one person at a time.

With all that is known about the modern hospital and all that is spent for its planning, no detail is so trivial that it should be neglected. The hospital has a life of fifty years or more and every handicap to service, every annoyance to the patient should be considered in terms of the thousands of days the building will be used and the long procession of sick persons and nurses who live for a little time in its rooms.

Purchasing Groceries

Many hospitals are under considerable pressure from local dealers who wish to secure their business in groceries and other commodities. One hospital in a suburban community has solved this problem by preparing each Monday a list of all dry groceries required for the week. Duplicate copies are made and the representatives of any firms wishing the business are at liberty to call on Monday and quote on any items on these lists. On the following day orders are placed with the dealer whose figure is lowest for each individual item if he has previously given satisfaction. No dealer can well complain if he does not get business under this plan, nor can any would-be supplier feel that he is unjustly denied an opportunity to bid on the hospital's business. The method inevitably eliminates in time the small dealer who is unable to compete, as well as the firms who fail to meet specifications as to quality, delivery or other elements of service.—F. Stanley Howe, Orange Memorial Hospital, Orange, N. J.

Better Work—Better Pay

By W. A. REINHARD

Director, Department of Engineering,
Laundryowners National Association

IT IS important to production efficiency that we find out what makes operators interested in what they are doing. To answer this question, we must turn to the science of psychology. A number of instincts and desires govern human actions; let us see which of these concern the laundry department manager.

Management obtains results by making people want to do things; and employees want to do their operations perfectly when their interest is maintained. If we wish someone's muscles to make certain motions, we must somehow persuade his brain to give the necessary orders to the muscles. Management's problem, then, resolves itself into one of influencing the minds of others, and thereby directing their muscles.

In our opinion, there are five desires to which management must appeal in order to increase an operator's interest in her job. These are for compensation, security, good craftsmanship, competition, recognition.

Wages should be large enough to take care of the employees' present needs and enable them to set aside a portion for security in the future. It is a fairly well known principle that lower unit production costs are obtained with higher hourly wage rates. The reason for this low unit cost is that the desire for adequate compensation and security has been satisfied and this has increased the operator's interest in the job, which in turn causes her to put forth added effort, thereby increasing production.

Probably the most important appeal to be made by laundry management is to craftsmanship. All workers, regardless of type of employment, experience pride in themselves when they have done a job exceedingly well. Self-pride is a recognized part of good craftsmanship. The second demand in good craftsmanship is for expert leadership. Without the proper leadership of the superintendent, this requirement cannot be fully gratified.



Flatwork production records posted on the blackboard are being explained by the manager of a laundry.

It is necessary that the superintendent "sell" himself to his employees and prove to them that he has a knowledge of plant production superior to that of his individual employees.

A third incentive to good craftsmanship is some form of planning. We have all seen instances in laundry plants in which changes were to be made which were definitely an improvement over the old method, yet when these changes were put into effect they did not increase the production efficiency. Primarily this was because the management had not considered the employees when making the change.

In making changes of operations in the laundry organization it is well to explain in detail why they are being made and what results will be accomplished. In nine cases out of ten, employees will offer excellent suggestions regarding the proposed changes which will increase their efficiency and make the changes effective.

The instinct of competition—the urge to excel—is present in all people. If this instinct is properly controlled and directed it is one of the greatest forces toward increased efficiency and increased quality. It is expressed by a desire to compete with others with a view to demonstrating relative excellence or superiority over them.

Competition may be invoked in the laundry

industry by comparing the production or quality of two shirt units, or of two flatwork ironers, or by setting up the records of the individual operator and trying to have her beat her past best record.

The desire for recognition is merely a desire for praise. If the plant manager will take the time to praise his employees when praise is due, this will help them keep their interest in their work.

In order to gratify these basic desires of industrial workers the management must have an operating plan.

Offering a Bonus

The first step in the plan should be the installation of blackboards in all of the major laundry departments, the second, the posting of the hourly production records of each operator. The third step should be the offering of a bonus to the operator for beating (1) the best previous hourly record; (2) the best daily record; (3) the best weekly production record. The amount of the bonus should be increased as the length of time of measuring production records increases.

These bonuses are of course not offered simultaneously. Management should first offer the bonus for the hourly record and keep this up for a period of two to three months, depending upon how many times the previous record can be broken. (These records are based on the average per operator hour.) The operator will finally reach a high record in her hourly production average, which she is not able to beat. The bonus is then offered on a daily basis, increasing the bonus to 50 cents, assuming that the hourly bonus was 10 cents. The daily bonus operates in the same manner as the hourly one.

When the saturation point is reached on the daily basis, the time interval is increased to a week, and the bonus is increased to \$1. During this competitive period it is necessary that the superintendent guard the quality standards closely, to ensure quality production. When the saturation point is reached on the weekly basis, computations are made for an incentive payment method, and the plan is installed.

With this plan we appeal to all these industrial desires, since we have accounted for the desire of compensation and security by the offering of financial bonuses. We have not expected craftsmanship to take the place of the corresponding increases in wages, for we have paid bonuses for an increased effort of production in each operation, bonuses large enough to make it worth while for the operator to achieve higher production. At the same time we have justified the "leadership"

phase of craftsmanship, since we have sold the operators on the fact that management of the plant has the leadership ability to improve their hourly earnings.

During this competition period, the superintendent has gone out of his way to sell himself to the individual operators, and at the same time has trained the operators to use better methods and motions in their particular operations. We have stressed competition since we have set up the operator's best production record over periods of time and have urged her to exceed her previous best production record. We shall have taken care of the desire for recognition, since the superintendent will give the operators praise whenever they obtain the bonuses.

After the saturation point is reached on the weekly bonus plan, competitions can be started on which the wage payment plan may be installed. It is easy to understand that the installation of the wage payment rate depends entirely upon the hourly rates which the management wishes its operators to earn, and the average production which is obtained with the methods used.

It is now necessary to know the characteristics of a good wage incentive plan. There are five:

1. It must offer increased earnings to workers whose efforts result in above-average production.

2. It must offer a minimum guaranteed rate on the time basis, so that the worker will be adequately paid while learning or while waiting for work. This has a further advantage in that if at any time it is necessary to put the operator on a job for which no time value has been established, she may expect to work under the same time rate.

3. The method of computing earnings must be simple enough so that the worker may figure her own wage.

4. The incentive must be applicable to groups where total production depends upon the concerted efforts of a number of people, such as in a flatwork ironer crew.

5. The incentive plan must be fair to both the employer and employee.

Three Basic Factors

Before installing any type of wage payment plan, it is necessary to analyze the three basic factors influencing production—proper methods, skill and willingness—to see whether or not they can be improved. An example of the installation of the piece work rate for shirt finishing will help illustrate the points.

If the average production which an operator was able to produce on finishing and folding of shirts was 28 shirts an hour—a fair production performance, but not average as compared with

results of other plants using the same method—and the skill of the operators being compared was approximately the same, the main difference would lie in the third factor—the willingness and effort of that particular operator. The hourly rate of the operator is 30 cents, thus making the cost of finishing and folding 100 shirts \$1.082. By the use of the financial bonuses and posting of hourly records on the blackboard, the willingness of the operator was increased until she was able to produce consistently an average of 36 shirts an hour through the week. If management were to pay her the same hourly rate of 30 cents, cost per 100 shirts would decrease to 83.4 cents, making a savings of 24.8 cents per 100 shirts. The installation of this piece work rate, based on the same hourly wage, would not be offering increased earnings to workers whose effort resulted in production above average; consequently we should be violating the third characteristic of a good wage incentive plan.

In order to satisfy this characteristic, it is necessary that management share the savings made with employees; and in this case, management decided to give 50 per cent of the savings back to the operator, thus making the cost per 100 shirts 95.8 cents to management and effecting a savings of 12.4 cents per 100 shirts. The operator to earn her basic 30 cents hourly rate must

produce 31.3 shirts per hour. Since it has been proved that the operator can average 36 shirts an hour during the week, her hourly wage will be increased to 34.5 cents.

The same method of installing wage incentive plans can be applied to any department of the laundry. We wish to emphasize that wage incentive plans cannot be installed within a short period of time by this method. Accurate data must be accumulated and analyzed. By installing the wage payment plan in this manner, we are sure that the third factor which influences production, that is, the willingness and effort of the operator, has been at its highest point, and records accumulated have been fair to both the management and employee. We do not believe it advisable to offer financial bonuses until the production of an operator is at least average. The operators should be willing to give a fair day's work for a fair day's pay, and those operators whose production results rise above average, are rewarded by higher hourly wages.

Though the condition and layout of equipment may be perfect it will not be possible to obtain high production and low unit costs, unless the operator is willing to put forth her effort in operating the machines efficiently. It is the management's job to make sure that the operators are willing to put forth their best efforts.

Questionnaires — Welcome Them

A good portion of the time of hospital administrators, particularly if they happen to be in charge of what are generally recognized as "representative" hospitals, is taken up with answering questionnaires. Many of these call for information which has been supplied to other hospitals within recent months.

Naturally, if time permits, the hospital administrator, with the welfare of the hospital field at heart, desires to be of as much assistance as possible to other institutions and replies as fully as a busy schedule will permit. The unfortunate aspect of making these replies, often at considerable inconvenience or with disruption of routine work while certain data are collected and compiled, is that these replies are often filed away and no person reaps the benefit except the hospital or hospital worker making the inquiry.

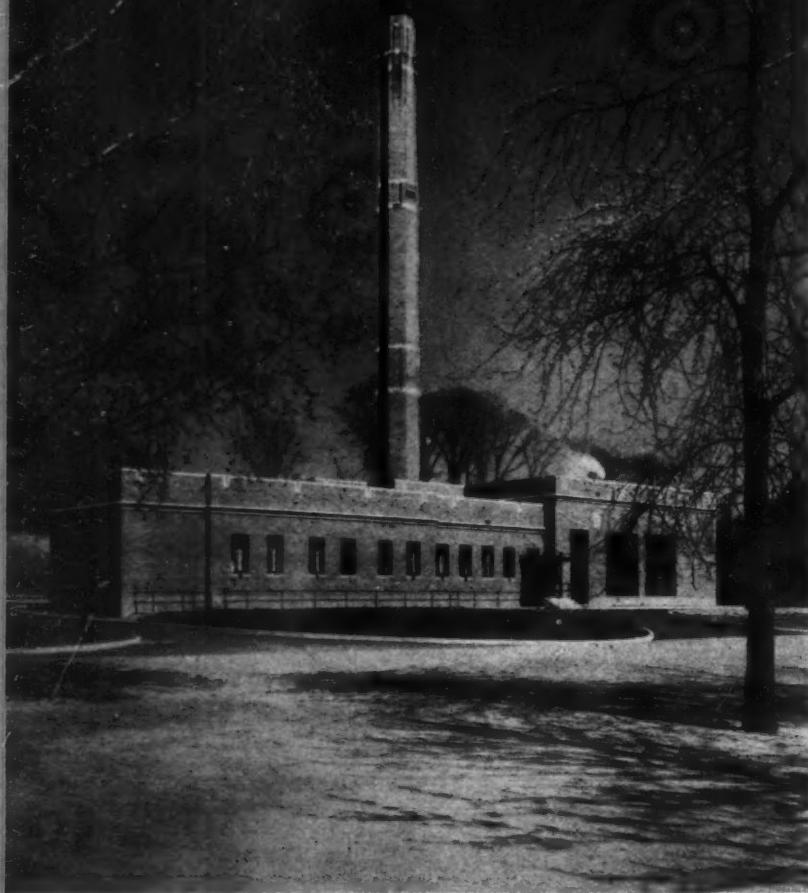
It would prove a tremendous boon to the hospital field if there could be established an unwritten law or tradition whereby the party collecting replies to questionnaires would summarize the replies received, preserving confidence where such had been requested, and then send a copy of the summary to all hospitals sending in replies. In this way information collected would be available to a larger number of those requested to fill out questionnaires, usually sent by utter strangers, and they would be more willing to give full and thoughtful answers, anticipating that these replies would be circulated among a larger

group of persons and would also return to him or her.

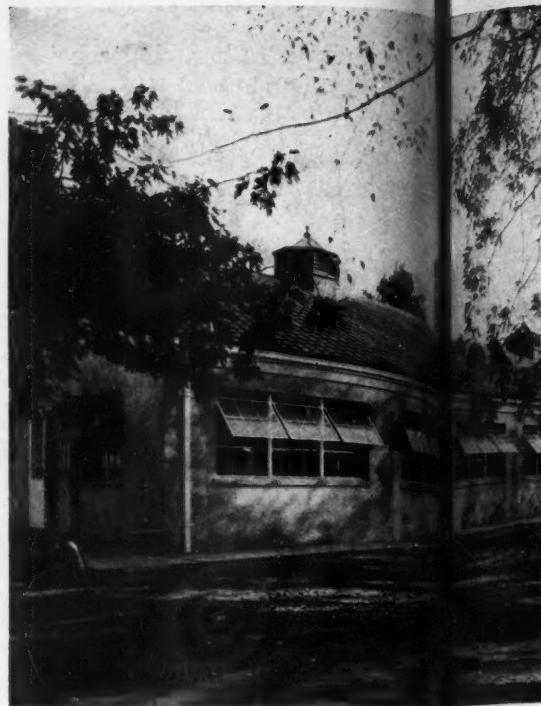
It should be kept in mind that many of the large national organizations in the different fields have already collected much of the information sought by the usual questionnaire and would be glad to pass these data on to any hospital making inquiry for such. When questionnaires are sent to individual hospitals and replies summarized, a copy of such synopsis should be sent to each of the leading national organizations, to the state association—when the inquiry is limited to a particular state—and to the editors of leading hospital journals.—*G. Harvey Agnew, M.D., Department of Hospital Service, Canadian Medical Association.*

The Finality of Doing Without

"Do without" is a phrase many of us have learned during the last few years. Administrators not only say it to others but often, in their self-discipline, to themselves. They have been compelled to say it frequently of late. However, when one has tried and cannot "do without" one need not take the administrative "no" as absolutely final. It is not always meant to be so. Sometimes it is a challenge to prove the need for something. Illogical preparation of supporting facts or poor presentation of a memorandum setting forth certain needs may account for rejection of a requisition.



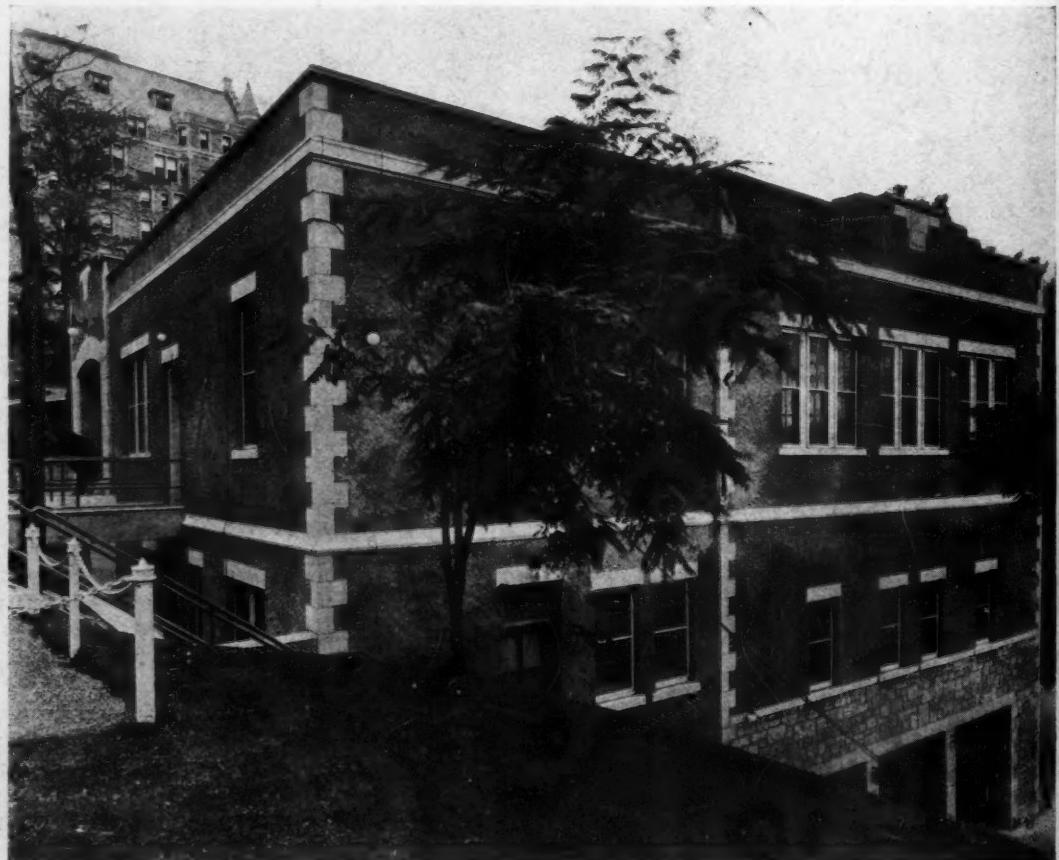
With its tiled roof and over-hanging trees the laundry and power house of Sacramento Hospital, Sacramento, Calif., is in keeping with the dignity of the other buildings.



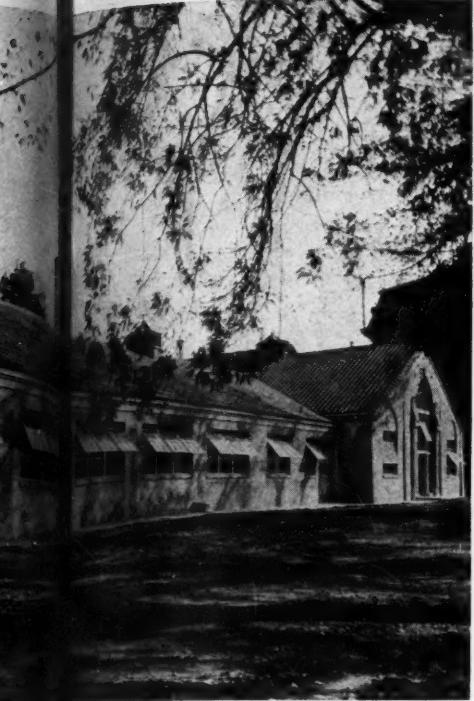
Power Plants Need

Through good design and
power plant, laundry and

The boiler house chimney of Springfield Hospital, Springfield, Mass., adds much to the beauty of the whole hospital layout. The architects were Stevens and Lee.



Royal Victoria Hospital, Montreal, built its laundry atop the ambulance garage, paint and carpentry shop. The new construction is of stucco with limestone trim to conform with the gray stone of the original structure. The architects were Messrs. Ross and Macdonald.

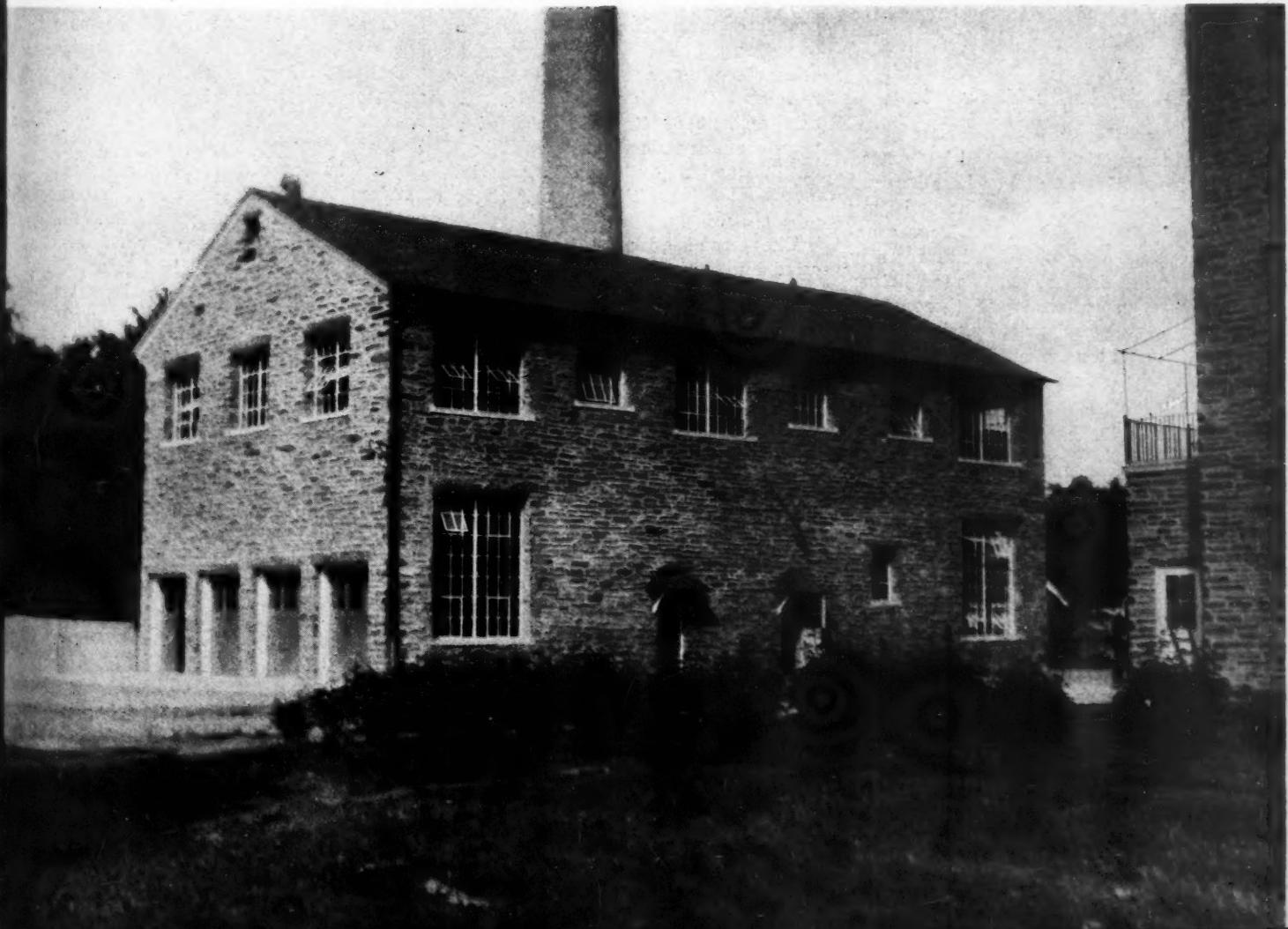


ed and and

Not Be Eyesores

artistic planting the
garage become assets

Great trees soften the outlines of the heating plant of Davis Hospital, Statesville, N. C. Benton and Benton planned the hospital buildings, which are situated on a large acreage. Below is the Early Georgian power plant, laundry and garage of Chestnut Hill Hospital, Philadelphia, planned by Willing, Sims and Talbutt.



Someone Has Asked—

Has Hospital Legal Responsibility in Drug Dispensing?

It is my opinion that all those engaged in dispensing or compounding poisons, drugs or medicines of any kind, whether in a hospital or not, should be registered under the Pharmacy Act and should hold a valid and subsisting license as a pharmaceutical chemist.

Broadly speaking, dispensaries in hospitals in Canada are subject to the provisions of the Pharmacy Act as enforced by the various provinces, which in principle makes it unlawful for any person, either as principal or agent or employee, to compound, dispense or sell drugs and medicines unless such person is a registered pharmaceutical chemist. In some sections where there is no pharmacist on the staff, the physicians are responsible or the prescriptions are filled by the local druggist. In two provinces exemptions have been granted from the enforcement of the Pharmacy Act in respect to hospital dispensaries provided that there is a doctor attached to the staff of these institutions. In other words it is mandatory that the dispensing of drugs be done under the supervision of medical men.—W. R. CHENOWETH.

Who Should Assist Courtesy Staff Surgeon?

This practical problem is submitted by a superintendent in whose hospital there is a regularly appointed visiting staff as well as a rather large courtesy staff. The question has recently arisen in this institution as to whether a surgeon on either of these staffs should be permitted to assign as his assistant at an operation the physician who referred the case to him. The rule of the hospital prohibits this practice, but a surgeon has recently strenuously protested that such a regulation is unfair.

This problem is not confined to any one hospital. There is one type of staff surgeon who recompenses a referring doctor by permitting him to serve as his assistant. It is suspected that the referring doctor receives as a reward something more than experience, in that the patient is sometimes required to pay not only a fee to the operator but one to his assistant. The ethics of this procedure would not be

so doubtful if the patient's bill always included a clear statement as to the amount of each obligation. Sometimes one bill is submitted and the surgeon unethically divides his fee with the assistant. This is of course a damnable practice.

There is another important angle to this matter. The assistant is usually not highly trained in surgery and cannot render the same type of skilled aid as can even the surgical resident physician. It seems, therefore, that a strict observance of the rule which prohibits a family physician not on the surgical staff of the hospital from assisting at an operation should be firmly required. A division of fees under any guise should not be countenanced.

What Is Essential to a Good Staff Conference?

The first essential is staff material of proper quality in sufficient quantity. Not all hospitals can meet this first requisite. Many small hospitals have only ten or twelve men on the staff and frequently as few as five or six, with only about half of these graduates in medicine of the last ten or fifteen years. Therefore, in considering essentials for a staff conference, remember that you must have a certain amount of staff material of a proper quality. In some of the best of the smaller hospitals this material may be lacking either quantitatively or qualitatively.

The second essential is an interested and active program committee.

The third essential is focusing the program upon the work of the hospital. Do not run in scientific papers as a part of a staff conference unless such papers are directly related to programs. At one meeting, let a committee designated by the program committee review the appendectomies that have been performed in the hospital during the last six months, twelve months or two years, depending upon the size of the hospital; at another meeting have a different com-

mittee review the gall bladder operations of the last three, six or twelve months; at other meetings let other committees review the work on such other diseases as pneumonia or eclampsia, using as a basis the clinical records of the hospital.

This sort of thing stimulates the staff to keep good records, and good records are the best means and the most complete guarantee for the development of two profoundly essential qualities on the part of a staff: thoroughness and real scientific interest.—W. S. RANKIN, M.D.

May Same Intern Care for Nursery and Children's Ward?

This question is asked by an executive of an Eastern hospital who has been requested to combine the intern services of the nursery and the children's ward but hesitates to do so because of the possible transmission of infection from the children to the newborn. This is a perfectly logical stand to take.

It is a well known fact that a staphylococcal infection possesses death dealing possibilities once it arises in the nursery. The many types of infection commonly treated in the children's ward give rise to the danger of their transmission to the nursery if the same intern handles both types of patients.

Such an opinion does not mean that theoretically it is impossible to combine these services safely. An aseptic technique of hand washing, gowning, and sometimes masking makes the transference of infection from one patient to another improbable, almost impossible. Interns are often no more careless than staff officers. If hands could be scrubbed and gowns changed after the examination of each patient, there would be little danger of crossed infection. Due, sometimes to ignorance, more often to carelessness or stubbornness, physicians too often fail to take these precautions.

Safe as it might be in the exceptional instance for maternity interns to assist at operations on infected cases or visit the postmortem room, so might children's ward interns also care for nursery patients and only good result from this arrangement. As a general rule, however, neither of these proceedings is advisable.

If you have any questions to ask, the Editors will be glad to discuss them in a forthcoming issue

The Pathologist's Place—

By LALL G. MONTGOMERY, M.D.

Ball Memorial Hospital, Muncie, Ind.

DURING the late years of the last century and the early years of the twentieth century the clinical pathologist has assumed an increasingly important place in the care of the patient.

Our major premise is that the services of the pathologist should be rendered as fully as possible to the largest number of patients. Service is the watchword of the medical profession and should apply as freely to the clinical pathologist as to the general practitioner.

Our first consideration is naturally enough the physical and personal equipment of the laboratory through which the pathologist carries out his work. It should provide adequate space and equipment for standard laboratory procedures. It should be served by a suitable number of trained technicians, and it should be supervised as closely as possible by a competent clinical pathologist. These provisions are fundamental and I believe are widely accepted as such.

Dr. H. T. Karsner of Cleveland in an article in the April 25 issue of the *Journal of the American Medical Association* discussed these phases of laboratory practice. Let us therefore leave these more mechanical matters and consider more specifically the social economics of laboratory medicine. Let us assume that the laboratory is ideal and its personnel adequate. Now, how may we in the laboratory best serve the sick of our community?

No laboratory can subsist on enthusiasm no matter how ardent, and a satisfactory method of providing an income is necessary. In some cases blanket charges are made against all patients entering a hospital; in other cases the laboratory work is charged by the piece. Each of these methods has advantages and disadvantages, but it appears to me that the latter method is preferable to the blanket charge. It is difficult to establish a fair flat charge if progressive laboratory

is at the doctor's elbow beside every bed, in the operating room, at the record desk

medicine is to be practiced. When new and more numerous laboratory methods are being developed the blanket charge soon becomes inadequate and might act as an inhibiting influence on progress. Let us therefore consider the test by test method of making charges.

I think that all of us have an overdeveloped sense of the monetary value of laboratory tests, but quite apart from this we often apply poor economic principles to the practice of clinical pathology. We forget that the cheaper the test the more likely it is to be used, and the more tests one does the cheaper one can do them. This sounds suspiciously like perpetual motion, but the principle is sound if it is not carried too far. We should first decide the lowest practical amount for which each test can be performed and establish that as our fee. However, we must be sure that we can actually do the test for that amount, for it is far easier to lower a fee than it is to raise it; and as soon as we begin to go in the red just then will our ability to serve be jeopardized.

The fees should be lowered as opportunity permits and it is more important to lower some than others. The point of attack on our price list should be governed by the importance and relative frequency of the test. Some laboratory examinations are essential, some are academic and experimental. For instance, urinalysis, leukocyte counts, hemoglobin determinations and tests for syphilis rank high in the category of essential tests. No patient should be deprived of work so important as these because of costly fees.

It Pays to Do Free Tests

Free work is dependent on the type of hospital practice and must be worked out to suit local exigencies, but in the average general hospital it is better to do an essential test free than to omit it. This is, by and large, sound ethically and economically. For example, we recently made a survey of the serologic practice in our part of the state and were aghast at the small numbers of tests for syphilis that are being performed. A personal survey showed that this lack was largely

due to the high cost of the serologic tests. Our attempt at solution of this difficulty was not ideal but showed the possibility of a solution. We gave our staff the opportunity of having a test for syphilis done on every patient who had a complete blood count and urinalysis. This covered nine-tenths of our patients. But the thing which I want to bring out is this — this arrangement increased our serology 420 per cent, but at the same time the amount of work done apart from the free work increased 180 per cent.

Free work, however, must be approached with the greatest caution, for the hand that feeds may be bitten. Fortunately the large majority of average hospital patients are able to pay. They are patients of moderate means who can bear a small laboratory bill, but may be embarrassed by an illness such as diabetes where an extensive amount of laboratory work must be carried out.

We have attempted to solve this difficulty in part by adopting a sliding scale of discounts extending from 5 per cent on bills of ten dollars to 20 per cent on bills of over twenty dollars. Another method of reducing fees fairly is by grouping certain routine laboratory measures and giving discounts on these groups. For instance, several blood chemistry tests on the same sample of blood should, I think, cost the patient less than when each test is done on a separate blood sample. When discounts are allowed on such work, the charges should be applied in full and the discount subtracted on the statement which the patient receives. This shows the patient that an attempt is being made to lighten the burden of the cost of his illness.

No Need to Hide Our Light

Let us consider that we have adequate physical and personal equipment and a fair method of charging for our work. We still have not discharged our duty to the patient. Someone once said that if anyone made a better mousetrap than anyone else the world would beat a path to his door. It is easy to see that this was before the days of modern advertising methods. I hesitate to mention a subject that is so taboo in the medical world but it is obvious, I think, that we must have some means of informing those who use the laboratory of its facilities. The time-honored grape vine has its place, but while laboratory medicine is progressing as rapidly as it is we must save time by a more direct approach. I am firmly convinced that we owe this to the patient as truly as we owe adequate technical laboratory work.

I do not mean advertising in the sense of the radio and newspaper. Our service to the patient is largely indirect. It is through the physicians

that we serve the patient, and on the skill with which they use the laboratory depends the success of our work. Physicians are not usually laboratory men themselves and so must depend for their laboratory work on the clinical pathologist. Thus a close association should be maintained between the laboratory personnel and the medical men of a community.

Conferences Play a Big Rôle

The laboratory head should be the clinical pathology encyclopedia for the medical practitioner. It goes without saying that the pathologist should have sufficient journals and reference material to fulfill this function. Also sufficient opportunity should be given all concerned for passing this knowledge of laboratory procedures from one to the other. One of the most important means to this end is the clinical pathology conference. Such conferences should be held as often as possible and should be planned to maintain the interest of the staff and to provide a maximum amount of useful information in a minimum amount of time. We have found it useful to devote each conference to some special field of laboratory medicine, using available clinical and pathologic material as illustrative matter. A corollary to this work is the reporting of all autopsies and these cases should be used to illustrate the application of laboratory methods.

Conferences have a large place in the life of a laboratory but they will never take the place of personal conferences between physician and pathologist. Some pathologists object to the amount of time they must spend discussing cases with staff members, but this, I am confident, is the basis on which laboratory practice should rest. It is the liaison par excellence between the laboratory and clinical medicine. The pathologist should always be available to the members of the medical staff for consultation or discussion of cases. He should attend ward rounds regularly and be prepared to take his part in the discussion of the cases presented. He should be at all staff meetings and should have his contribution to offer in any place where laboratory medicine is discussed. In fact, if a hospital superintendent is the all seeing eye of the general hospital personnel, the pathologist should be the all pervading presence whenever patient and physician meet. His place is at the physician's elbow beside every bed, in the operating room, at the record desk. No function should be too trying nor any problem too small for his attention if he is able thereby to assist in the care of the patient.¹

¹Read at the meeting of the Tri-State Hospital Assembly, Chicago, May 6 to 8, 1936.

When Is a Student Not a Student?

By ARTHUR M. CALVIN, F.A.C.H.A.

Executive Secretary, Minnesota Hospital Association, St. Paul

Twenty-five states unqualifiedly class student nurses as employees, four more do so if the students are paid, six count them as students and three are in doubt. Would these classifications hold in court if a student nurse claimed compensation insurance?

EVERY person connected with hospital administration, nursing education and education in general would undoubtedly answer the question, "Are undergraduate nurses employees or students?" in the following manner: Undergraduate nurses today are unquestionably students.

In the field of insurance there is a difference of opinion as to whether or not a student nurse is an employee or a student. This refers primarily to compensation insurance. The industrial commissions of several states have given definite status to the students of an undergraduate school as being employees of the hospital. Some states do not require that student nurses be covered by compensation insurance and others classify the student as an employee if she receives compensation in addition to her maintenance.

The report of the Committee on the Grading of Nursing Schools contradicts the statement that student nurses are even apprentices! "Much nursing literature implies that each student works side by side with a graduate. She learns not by practicing alone but by working under the constant direction and in close companionship with a graduate skilled worker. Nursing does not use the traditional apprenticeship method of teaching because it does not have students working side by side with graduate nurses in anything like a one to one relationship."

The student nurse begins her course of study with a four-month preliminary period giving but a few hours of service each day during those four

months. She has three weeks' vacation and a period of several weeks' affiliation with other hospitals in pediatrics, public health instruction and general practical experience. The student nurse today is a far cry from the student of yesterday. Many of the duties of the former student nurse are now performed by hospital maids.

We have been informed by the reports of the grading committee that several schools are still paying the undergraduate nurse an allowance. Whether this allowance is to be construed as a salary, to determine whether a student nurse is an employee or a student, is worth careful consideration by the groups who are sponsoring the higher education of the nurse and by hospital executives who are paying for compensation insurance.

Thousands of Dollars Paid — for What?

There is apparently no objection to hospitals carrying insurance on their nurses. The question now facing the hospitals, in states where compulsory compensation is required to cover the student nurse, is whether, during the years that this premium is being paid, the student is actually protected. Would she reap the benefit in case any state supreme court ruled that an undergraduate nurse is a student and not an employee, and therefore is not entitled to compensation insurance? Thousands of dollars are paid annually for this type of insurance but the protection obtained is uncertain because of indefinite classification. If compensation does not cover the student, she could still be protected under employees' liability insurance privately purchased by the hospital to cover any negligence on its part.

It is interesting to note that the compensation insurance board of Minnesota was inclined to feel that the student nurse who pays a tuition fee to the hospital school of nursing and does not receive any compensation except board and lodging, may be considered a student, the same as a student at a university or college who is earning his expenses by working his way through. The board would not definitely construe the compensation act to exclude undergraduate nurses until a case was

actually tried before the state supreme court.

States which include student nurses as employees protected by the compensation laws are the following twenty-nine: California, Colorado, Connecticut, Delaware, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Michigan, Missouri, Montana, Nebraska, New Jersey, New York, North Carolina, North Dakota, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Utah, Virginia and West Virginia. Of these Florida, Indiana, Louisiana and Michigan qualify their answer by stating that nurses are considered employees only if they are paid. Missouri replied that the question had never arisen.

Six states do not consider student nurses as employees, namely, Alabama, Nevada, New Mexico, Oregon, Washington and Wyoming.

Three States Still in Doubt

Three states—Arkansas, Ohio and Vermont—have apparently not settled the matter. "Ohio has experienced difficulty in the matter of determining whether student nurses . . . come within the scope of the . . . act. No specific ruling has been made and the dual relationship makes this a difficult problem." In Vermont the compensation act is not compulsory for charitable, religious or educational enterprises. As to other hospitals, the interpretation of the industrial commissioner is that "student nurses, if paid something in cash for services in addition to the education . . . and room and board, are employed to the extent of the cash wage. If the student received room and board for a three-year period under her nurse's training arrangement and was injured so seriously that she could not continue her training and did not after the injury receive the board and room, I would think that the room and board should be considered under our statute as part of her wages in addition to the cash wage."

In Arkansas the interpretation is reported to be "governed entirely by the nature of the contract."

In Montana the commissioner reports that heretofore student nurses have not been considered as students but believes they could be placed in this category the same as any other student working his way through school.

In Nevada they have gone further. The commission reports: "We have never in this state held that student nurses come under the provisions of the industrial act and we feel they should be rated as any student of any university or institution of learning. They are not working for compensation and therefore could not be deemed to be persons who would come under its provisions."

The Colorado commissioner, on the other hand, feels that there is a vast difference between the student nurse and the student in an ordinary school or university. The former is undoubtedly performing some form of service for her education which, of course, is not ordinarily the case in a university.

"While it is true that they are students in learning," replied the commissioner in Texas, "we believe that their status would be different from the ordinary student in that the hospital is not run as a school for the nurses but the nurses are only incidental and they do the work necessary to the maintenance of the hospital while training and are remunerated therefor."

The same point of view was expressed by the Iowa commissioner, who said: "In any of the varying relationships existing in different hospitals, such worker receives substantial benefit in the way of training for lucrative employment in addition to at least her board and room and, in some cases, a small monthly payment. This, it seems to me, decides the status as employees rather than students in a compensation sense."

In Illinois "hospitals are considered as a business as far as the compensation act is concerned and student nurses are treated the same as all other employees." In Nebraska, whenever the relation of master and servant is established, injuries which arise out of and in the course of employment are compensable.

The question is obviously an open one. Before paying the compensation insurance, however, the hospital superintendent should take steps to make sure that his student nurses will in fact receive the protection for which his hospital is paying. Furthermore the nursing groups may wish to study this problem carefully before making too complete a divorce between nursing education and hospitals.

Manufacturing Ice Cream

A satisfactory arrangement for manufacturing ice cream and other frozen desserts may be had through the installation of one of the various ice cream freezers now on the market. Almost any frozen dessert can be manufactured in the hospital, in a room set apart for this purpose, at a fraction of what it costs to buy these commodities.

Ice cream mix can now be purchased from dairy manufacturers and shipped to hospitals from distances of several hundred miles. The expense of installing such a room is nominal in view of the saving that can be accomplished in manufacturing these products. It has also been found that a much better and purer product can be manufactured by the institution than is generally sold commercially.—George D. Sheats, *Baptist Memorial Hospital, Memphis, Tenn.*

Elements of Success

This vital subject was dealt with by Doctor Doane in this address given at the opening of the Cornell University summer course for hospital administrators held at Ithaca, N. Y.

By JOSEPH C. DOANE, M.D.

ARE the things that will cause your communities and boards of trustees to acclaim you of a material or a spiritual nature? Is the balance sheet of your accomplishment one that is always justly computed?

The factors which produce praise or censure are not always of great proportions. Many are of the most picayune nature. Moreover, the composite opinion of a board of trustees or a community as to the excellence which characterizes your work is often not the result of either a judicial or a just consideration of all of the facts. Accomplishments may be interpreted by some as synonymous with success, while by others they may be considered trivial, unimportant and of little moment, either professionally or socially. And so in our lives as hospital executives many moments will be filled with an overwhelming consciousness of failure, of discouragement, of a knowledge of lukewarm community approval.

In what concrete terms may we measure the presence or absence of success? Figuratively, let us place ourselves outside of your hospital and survey its architectural and service possibilities. Your institution is the physical agent loaned to your board of trustees to meet a definite community need. As your public passes by, let us learn from it what is expected of this institution.

Some will promptly reply that success in hospital work means above all else the showing of a business profit. Some measure hospital work in terms of its scientific achievement. To others, the hospital represents a home or a hotel for the sick. Some affirm that it is a refuge which should unfailingly render aid, no matter what may be the nature of the dilemma or distress that befalls a family. Fortunately but a minority look upon the institution as a plaything of politicians where the

need for training and for a social understanding of the complex problems of disease are subordinated to the selfish instincts of a party or a person.

To meet fully all the laudable expectations of the public and to repulse the advances of the ignorant and the greedy is truly a Herculean task. Let us therefore ask ourselves some basic and pertinent questions, and together let us endeavor to answer them.

Is business success the highest aim for which an institutional executive should strive? To be sure it is essential to secure funds with which to meet the obligations incurred in the care of the sick. The business management should be characterized by the highest degree of efficiency and the community dollar must, at times, be spent with a care that amounts almost to miserliness. This is particularly necessary because the economic problems confronting the hospital executive are often more complex than those encountered in many activities of even greater financial proportions. Here is an institution rendering a salable service which must frequently give away fifty cents of each dollar and endeavor to exist on the remainder.

Solvent — Yet a Failure

Because of this almost impossible financial problem, a great temptation exists either to indulge in sharp practice or to assume the almost equally reprehensible attitude of "saving strings." Now, dishonesty or cheapness in thought or practice is not the price of balancing the budget. To obtain funds to meet pressing bills promptly is necessary and laudable, and yet a hospital may be an abject social failure and still be wholly solvent.

Too often boards of trustees think that success in hospital administration must always accompany the efforts of the institution that employs no red ink. As a result of this misbelief, too frequently an ethical and highly trained executive who is meeting all the expectations of his community is

dismissed and a business failure full of grand promises is appointed in his stead. A man who cannot succeed in his own business is hardly likely to do so when conducting that of another.

A hospital able to achieve highly scientific work is much to be congratulated, but such an institution will fall far below meeting the needs of its clientele if it is cold, superefficient and callous toward human suffering. Indeed, it is questionable whether the average community hospital can efficiently pursue that will-o'-the-wisp called "scientific research" except under the most favorable conditions.

The psychology necessary to the work of the general practitioner and that of the research worker have but little in common. To delve deeply into the secrets of life and death is not inconsistent with the humane and efficient care of the sick, and yet it is probable that the average general hospital had better stick to its last, which is the care of the sick, and leave to others better equipped in personnel and materials the search for the cause and the cure of many of our unknown diseases.

There is a marked difference of opinion as to the similarity between successful administration of the hospital and of the hotel. Whatever you and I may believe, the hospital executive may learn much from the hotel manager and the latter, perchance, might derive some benefit from the former.

The science of saving is common to both. But the mental attitude of those who care for the sick, of those who seek only economic life rather than a profit, of those who dispense health preserving precepts to their communities must be strikingly different from that of those who cater to a pleasure or business seeking clientele. Success in one field in no way guarantees like experience in the other.

Training Courses Needed

As yet no wholly satisfactory course for future hospital executives has been originated and carried through. Should such a curriculum be included in courses conducted by a medical school, a school of business or in connection with the instruction offered to those who are preparing for hotel work?

It is conceivable that the requirements as to engineering, architecture, chemistry, accounting and possibly dietetics and personnel management might be roughly common to each endeavor. Perhaps some institution of learning may some day offer a four-year course for hospital executives in which the first one or two years are given in common with some other group such as hotel execu-

tives, the last two being specifically devoted to medical terminology and practices, field work and preparing to meet the specific problems of the hospital administrator.

There is a growing belief that your hospital should represent a haven of refuge in your community no matter what befalls the members of your clientele. Let us acknowledge the necessity of pliability, of breaking rules when necessary to meet community needs, of reorganizing and reconstructing the hospital administrative set-up and practices when necessary to meet the new and ever changing needs of the people. Whatever the service required, whether it be of a curative or a preventive nature, or even one which aims at reuniting a broken family circle or offering advice on child guidance, the hospital should not be found wanting.

Political Interference Is Condemned

There seems to be a distinct trend in the past half decade toward political interference in the work of the hospital. This is particularly true in states where there are hospitals either completely owned by the commonwealth or where the state aid system is in force. From time immemorial, the politician has considered that the *quid pro quo* for public grants to hospitals is the privilege of securing patronage or free beds for the friends of the person or party in power. The grimy hand of the political grafted is more and more tightening on the throat of such hospitals. Qualifications, understanding of the sick, administrative efficiency, long years of experience are as nothing to the individual who would build a political machine at the expense of the sick.

The unfortunate angle of this distressing situation is that there are none who can effectively cry "enough." What force is there that can make greedy brains think aright, and how may we disperse the threatening cloud of politics within and without our hospitals? It is to be hoped that this threat to institutional efficiency which seems now to hover over the whole hospital field is but a passing phase of our all too confusing national life.

But let us turn our attention to some of the personal traits we may truthfully consider as elements of success in hospital work. The institutional executive must be an individual of the highest personal probity. He should be a fine example of sobriety, of honesty, of dignity and fair dealing at all times.

The executive who in making his rounds, figuratively wearing the uniform of duty, thoughtlessly addresses his subordinates by their Christian names falls far short of my ideal of dignity. Refu-

sal to procrastinate or compromise with the wrong, patience and long-suffering toward those who err, discipline characterized by firmness and yet by understanding and kindness, a judicial mind willing to listen to extenuating circumstances in the case of an offending hospital worker, all these traits should characterize a successful hospital executive. When a verbal altercation occurs in the superintendent's office, the administrator should be certain that the fault does not lie largely at his door. Indeed, there are those who believe that it is never excusable for voices to be raised and hot words to be employed within hospital walls.

Personal Practices Important

May I be a trifle more personal in describing these traits which we must manifest? Smoking, except in the privacy of a room set aside for that purpose, is hardly consonant with good hospital practice. The use of alcoholics of any sort in the presence of nurses or hospital workers is not to be excused. The entertaining in your own homes of some particular hospital worker without including all others of the class is unwise.

A prolonged absence from the hospital, even though granted by your board and necessary for your attendance at conferences or in search of rest, is likely to be a disorganizing influence. Punctuality is a virtue to be sought. Church or lodge activities in your local community are to be encouraged but care must be taken that neither in business dealings nor in your administrative actions is anyone given any excuse for supposing that such affiliations govern your official decisions.

If you live in your hospital, your actions must be even more closely watched than if you occupy a separate home. In the former condition, you may enjoy no real family privacy. Your home life must be almost as if your house were composed of glass. What you eat, what you do, almost what you think, quickly become the property of the patients and employees. This is a difficult and, it seems, an unfair situation. In your home it is your own business when you invite friends to dine. In the hospital it is considered a concern of everyone. If there must be disproportion between the living accommodations of yourself and the provisions for the care of the sick, let the balance fall in favor of the latter. This is particularly true if you are expending the money of the taxpayer.

If the executive and his family dwell on the hospital grounds, unless holding an official position on the administrative staff, the wife of the superintendent should probably remain aloof from close contact with the hospital and its personnel. Some embarrassing situations have arisen throughout the field because of the executive's wife assuming

administrative authority during the absence or even the presence of her husband. Nepotism is as harmful in hospitals as in government work.

These statements may appear trivial and yet it has been the experience of many hospital executives that such matters magnified in importance by their passage from tongue to tongue have exerted a determining influence on the tenure of office of the hospital superintendent. It is curious, indeed, that the better the living conditions, the higher the salary, the more pleasant the work, the more quickly will a hospital executive's position be coveted by others. If you are seeking a new position, be sure that you are qualified to expect within reason that success will follow your efforts. If you are leaving an old one, leave behind you a reputation for composure, for abhorrence of petty gossip and for fairness to the stick whom you have served.

Success consists in speedily sparing suffering and danger to the patient. Failure consists in an inability to restore health and usefulness. Success often must be a matter of having an inner consciousness of accomplishment. Success must follow the work of that person who, well equipped in his profession, follows the admonition of Sir William Osler to perform to the very best of his ability each day's work, entertaining no thought for the day which is to come.

Teamwork Between Departments

A vital service which department heads can perform for the benefit of the hospital is that of encouraging in their departments a belief in the excellencies of other departments.

It might be well for the department head to begin by convincing himself of such excellencies. This needs a sympathetic understanding of the problems of other departments, the activities they have to carry on, the equipment they have to do it with, and the limitations of the personnel, individual and collective. Ignorance of such facts is the basis of most interdepartment criticism. It can't be a matter of relative merit, because it goes both ways. It might be mentioned, as a matter of general observation, that the more competent the department head, the less criticism there will be of other departments.

It is obvious that this does not refer to major, remediable defects. If department heads make a business of being on friendly terms with other department heads, these may be discussed with profit to both. Where this fails, the superintendent should be brought into the picture. Much of the trouble will be found to be misunderstanding. The rest of it can be solved, or, if inevitable, explained, so that it ceases to irritate.

It is not enough to be loyal to one's institution; loyalty to every part of it is called for, and if each department sets itself the task of making easier the work of every other department, the institution as a whole will be more worthy of our pride.—John R. Howard, Jr., Muhlenberg Hospital, Plainfield, N. J.

PLANT OPERATION • • •

Conducted by John R. Mannix and R. C. Buerki, M.D.

An Analysis of Dishwashing Methods

By John Gorrell, M.D., and Nellie Gorgas

Superintendent, Falk Clinic, University of Pittsburgh, and
Assistant Administrator, University of Chicago Clinics

DISHWASHING is an orphan. The head of the dietary department finds it an unwelcome child whose presence is vital but not desired; almost a necessary evil. This frequently results in a poorly planned room; insufficiently foolproof equipment and untrained, unenthusiastic, overworked employees of low efficiency who produce low grade work at high cost.

There are two criteria for clean dishes: visible cleanliness and sterility. All too often visible cleanliness is used as the only index. The bacterial count, but more particularly the kind of bacteria, should be a common standard index as well. Dishes spotted with food may yet be sterile as a result of heat or chemicals and dishes that look clean may have a high bacterial count.

Bacterial count by any method short

of culturing is worthless. Furthermore, unless bacteria are pathogenic there is nothing in their presence to cause great alarm. A visibly clean dish may easily be rendered sterile and this final step in the washing process must not be overlooked. A sterilizing chemical, such as chlorine, or a rinse of not less than 170° F., is required by many city ordinances. As in all other tests and statistics, intelligent interpretation must be used in judging the dishwashing process.

Cumming¹ proved the significance of eating utensil sanitation and health by observation at Camp Tanforan, Calif., in 1917. In an epidemiologic study of more than 66,000 troops, the influenza rate was 51.1 per thousand for those who had collective dishwashing, as contrasted to a rate almost five times as high, 252 per thousand,

in the case of those who washed their own dishes in warm water. In another group of almost 6,000 troops, it was found that boiling water gave 85 per cent protection against saliva borne infections.

Cumming² also reports a study of public institutions where more than 250,000 persons were fed. Where hand dishwashing was used there were three times as many influenza patients as among those served on machine washed dishes. The laboratory proved conclusively that 99 per cent of the organisms left on dishes were removed by dishwashing with machines and only 78 per cent by hand washing.

Dearstyne³ found and thus confirmed the usual understanding that the highest cultures were on utensils that came in contact with the lips. Cups, glasses and spoons were the leading public enemies. This is significant when one recalls that many large and small institutions have no glass washing machines and do not send glassware through the dishwashing machine because of breakage and the effect of sterile but streaked glasses.

Wells⁴ found that some bacteria were always added when dishes were wiped. He adds that "scalding the dishes destroys most, if not all, of the germs on the dishes."

The army and navy regulations call for a wash temperature of 65°C and rinse of 100°C. (149° and 212°F.)⁵

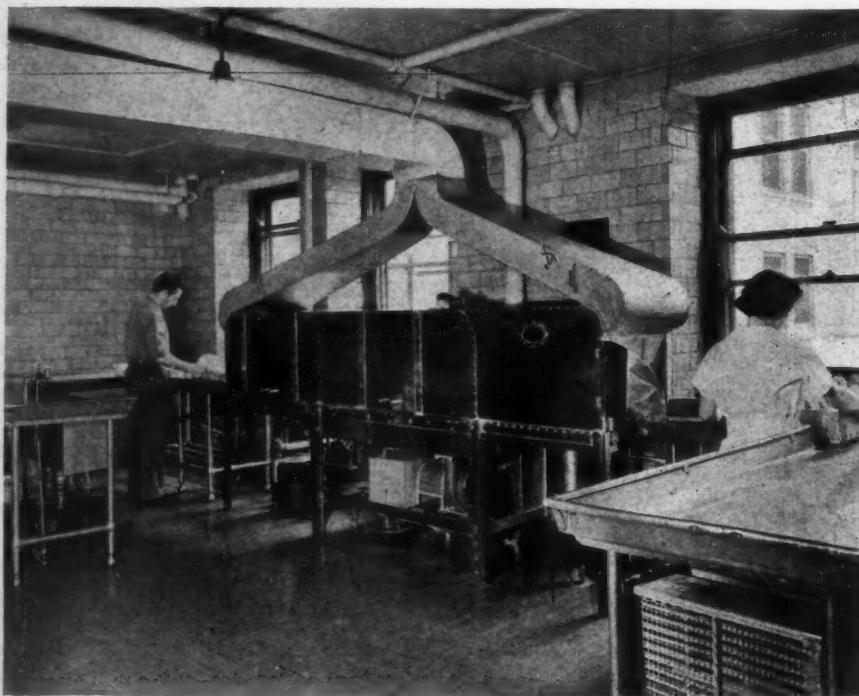
Perfection would demand that the dishwashing machine receive all dishes, silverware and glassware in one end and deliver them at the other end washed, dried, sorted and stacked. Such equipment is not commercially available and might be too expensive to be justified. The following processes are essential and the average machine accomplishes one or more of those marked with an asterisk.

(1) Rough cleaning: scraping dishes and silver, rinsing table size milk bottles; (2) sorting and stacking; (3) pre-rinsing; *(4) washing; *(5) disinfecting; *(6) rinsing free; *(7) sterilizing by heat; *(8) drying; (9) polishing; (10) stacking.

Rough cleaning is the process of removing untouched food, paper napkins, apple cores and other items which will fall off a plate or out of a glass. Scraping is the removal of the majority of remaining food. A rubber tipped putty knife or similar instrument removes congealed gravy, cigarette butts and bottle caps. The greater the load on the employee, the more garbage is likely to go into the machine washing fluid.

Sorting and stacking by size is usually necessary because of limited space; otherwise dishes would be out of easy reach and might be broken.

Pre-rinsing is an operation which employees assume is done by the dishwashing machine. Therefore it is rarely done by the employee, and an



Dishwashing machine installed at the University of Chicago Clinics. The picture shows the rack of dishes going into the machine. After they come out they are placed on wheeled racks to be taken back to the dish room.



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BE HAPPY TO GET HOME
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astounding amount of residual food is found on dishes entering the wash chamber. Some manufacturers have recognized this and are trying to meet the situation by having two separate washing chambers with the dishes going through one into the other.

Washing is done thoroughly by the average dishwashing machine if a thorough rinse has preceded this process. However, since proper pre-rinsing is rare and almost every machine recirculates its washing fluid, débris accumulates in the fluid (usually 60 gallons or less) and a dilute garbage soon becomes the washing medium. It is true that the washing fluid is continually being diluted by the addition of some water, but this dilution is far too small to change the picture.

Disinfection or sterilization may be accomplished by a germicidal chemical (as chlorine) in the washing water or by heating the utensils to or above 180° F. Disinfection is at least partially accomplished in a powder approved by a health department. Dr. M. J. Prucha^a urges that the type of preparation be warranted not to attack the metal of the machine. Doctor Cumming warns that available chlorine does not always mean usable chlorine.

Rinsing free and raising the temperature to 170° F. require a larger volume of water than most institutions employ. It is required by ordinance in Chicago that dishes be subjected to this temperature for at least one minute. The rinse water in most

machines flows into the washing compartment afterwards to dilute the washing fluid.

Sterilizing by heat, in lieu of chlorine or another sterilizing chemical, is acceptable. Many city ordinances demand that the rinse water be not less than 180° F. This should give a partial sterilization or at least pasteurization. The 180° water is perhaps preferable to chemical sterilizers because the latter often contain free chlorine or corrosive acting chemicals. In addition, if the scald or final rinse water is 180° F. or more, and present in sufficient volume, the dishes are raised in temperature to 180° and accomplish the actual pasteurization. This also makes the china sufficiently hot to air-dry.

Drying dishes by towel is specifically not recommended in most ordinances. The hospital should never permit it, for it is expensive in towels, breakage and labor, and it disseminates bacteria. Dishes that leave the machine at 170° or more in a well ventilated room will air-dry before they reach the stackers, usually a run of about 5 feet that involves two or three minutes' time.

Polishing is usually accomplished with drying. Dishes washed in hard water, with an improper washing formula or insufficient or unclean rinse water, have a fine powder on their surfaces. This may be strongly adherent or a loose powder in macroscopic amounts, especially noticeable on glasses and silver. If after con-

sultation with competent chemical firms the problem cannot be solved, polishing with clean but dry towels may be desirable.

Stacking is a final step that should take the dishes direct to the wheeled rack which will carry them back to their proper location. Additional handling increases labor, time loss and breakage and requires more space.

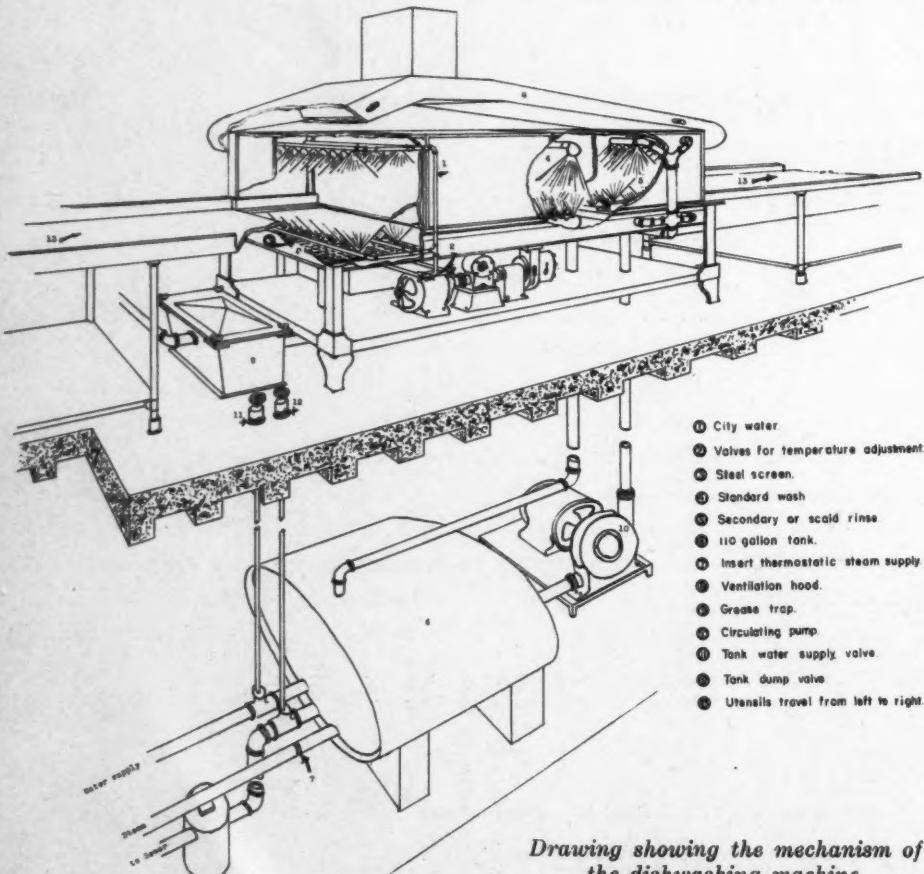
Evidently there are at least four steps in the dishwashing process which still require hand power: the rough cleaning, stacking, polishing and restacking. Here the greatest room for improvement would seem to lie in the careful arrangement of space so that waste motion is eliminated. The ordinary dishwashing machine cares for one or more of five other steps more or less efficiently, namely, washing, disinfecting, rinsing free, sterilizing and drying. There are obviously some major improvements which might well be made in most machines if all of these steps are to be covered thoroughly. The pre-rinse, not performed by most machines, seems the most vital need.

Avoid Complicated Apparatus

In selecting a dishwashing machine the administrator must watch carefully to obtain one which the employee, not the demonstrator or the administrator, can operate effectively. Simplicity of operation and upkeep will save the administrator many problems later. A machine which is automatic and foolproof, requiring a minimum of thought from the employee, would be ideal. It is less expensive to buy high-class sturdy equipment than to pay for continued expensive supervision and repairs.

An exhaustive study^a of three leading makes of institutional dishwashing machines was made. A recent product, a model five to seven years old and one of the oldest machines to be found in each group were studied. Each machine was examined under normal operating conditions. Some significant facts are:

1. The actual and practical capacity of the machines varied from 21 to 66 per cent of the manufacturers' advertised figures.
2. The machines gave a "cleanliness" percentage of from 50 to 99 per cent. Age was a small factor as compared to training of employees and machine maintenance.
3. Frequently an excess of 100 to 500 per cent of cleaning powder was used.
4. Only 50 per cent of the machines produced air-dried dishes.
5. The percentage of broken dishes was practically nil. High temperatures make it desirable to use underglazed patterns on chinaware.
6. Ten seconds are needed for rinsing and sixty seconds for washing. Rinse water should be 140° F. A five-



Drawing showing the mechanism of the dishwashing machine.

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BLUE . . .
Neoarsphenamine



YELLOW . . .
Sulpharsphenamine



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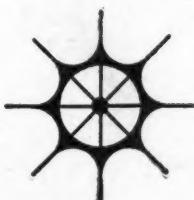
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second scald rinse took two minutes to dry whereas a ten-second scald caused dishes to dry in one minute.

7. In hand model machines, the machine period was twice that necessary for good work. Egg and cheese dishes should be soaked in cold water and brushed before being placed in machines.

8. Life expectancy of machines, the study seemed to indicate, is approximately ten years. Depreciation should be figured accordingly.

At the University of Chicago Clinics, Chicago, an attempt has been made to improve dishwashing by making certain changes in the dishwashing machine. These have not been costly and have proved of benefit.

Noticeably unsatisfactory results were being obtained from the ordinary single tank washer which was being used. Dishes were behind schedule, which meant more breakage and a demand for a larger inventory. The washing was not uniform and periodically at the time of peak loads the machine had to be shut down to permit the screens in the wash tanks to be cleaned. The amount of labor necessary appeared to be excessive.

Inspection disclosed that the general condition of the machine, which was about five years old, was good. Dishes were placed in dish racks and pushed through the machine by a strong-armed employee. When work was slack, dishes were overwashed; during the peak load, they were hurried through too fast for thorough cleaning. This was partially corrected by asking the manufacturer to aid in the design of a mechanism to push the trays through at a uniform and proper speed. A satisfactory mechanism was installed, thus freeing the strong-armed men and permitting women to do a larger share of the work. A drive with proper strength and speed control is essential and should be kept in mind by those who revamp their machines.

A Bad Situation

During this period, the service demands in the clinics were increasing rapidly. The great number of dishes to be washed and immediately returned to the cafeteria, coupled with limited space in the dishroom, resulted in almost unavoidable neglect of the rough cleaning process. In three hours' operation so much food and débris passed into the wash tank that the machine had to be turned off twice during the period and the screens removed and cleaned while the thirty-five gallons of wash water was dumped down the drain.

It was accepted as a painful truth that no employee would or could completely scrape the dishes. As a result, there was established a "waste wash" or pre-rinse. This was a series of upper and lower $\frac{3}{4}$ -inch brass pipes

through which city water passed and rinsed off the residual débris left after rough cleaning. The valves shown in the accompanying drawing permitted temperature adjustment so that egg would not be cooked on.

The most significant factor in the new scheme is that the rinse water runs through a large area of stainless steel screen to the drain, and is not recirculated. This results in wash water that is almost as free from food particles after three hours' run as at the beginning of the wash period, for the dishes are well rinsed before they enter the washer. The screen on the rinse-to-drain section has to be emptied several times, of course.

This will be improved by the use of a perforated bucket in place of the screen. With two such pails only momentary interruption of services need occur. There may be some objection to the rinse-to-drain plan because of the amount of hot water consumed. This is not as large as might be assumed, however, for the rinse water is kept at only a little over body temperature, or well under 150° F.

The Rinse-to-Drain Feature

This rinse-to-drain system is common to milk and other bottle washing equipment, but is found on no known standard dishwashing machine. Some of the more elaborate machines have two washing compartments. The difficulty here is that the water in each recirculates and in the first soon becomes dilute garbage just as it did in the one-tank machines. The rinse-to-drain system always supplies clean water for this rinsing operation.

With the washing chamber and its fluid protected, the machine performed more satisfactorily. The next problem was to eliminate the need for sterilizing chemicals and hand drying. The rinse on the original machine consisted of upper and lower jets from which water of 170° or more should have come. To have this temperature, however, it was found that it would be necessary either to raise the temperature of all the hot water in the building to an excess of 170° , or to have a temperature booster machine.

The first was impractical because of the cost and the danger of scalding patients and employees. The second was tried by using a special valve which injected steam into the water. The lime tended to precipitate in the presence of the steam. This fact together with the realization that the streams of rinse water were too small to be really effective, caused the principle to be reviewed. Even when the rinse water was somewhat in excess of 170° the amount of it was inadequate to permit the dishes to be actually heated above 150° or 160° .

A scald rinse of larger volume was installed with the idea of permitting the existing rinse to remain, impotent

though it was, and of adding a secondary or scald rinse. The final rinse pipe has now been changed to give a spray of water rather than streams, to ensure more thorough rinsing of dishes. A 110-gallon tank was placed in the sub-basement immediately below the machine.

The thermostatic control and valve of the scald tank must be adequate because ventilation and incoming dishes tend to cool this water rapidly. A thermometer on the rinse pipe shows the operator constantly whether the proper temperature is being maintained. Additional lagging has been put on the tank and the pipes recently in order to help maintain the required temperatures. A pump having a capacity of 40 gallons per minute permits the circulation of practically boiling water over the clean dishes. They are thus heated to not less than 170° in their brief trip through the rinse and come out so hot as strongly to discourage towel drying. When they are as hot as this, air-drying in an adequately ventilated room is relatively simple.

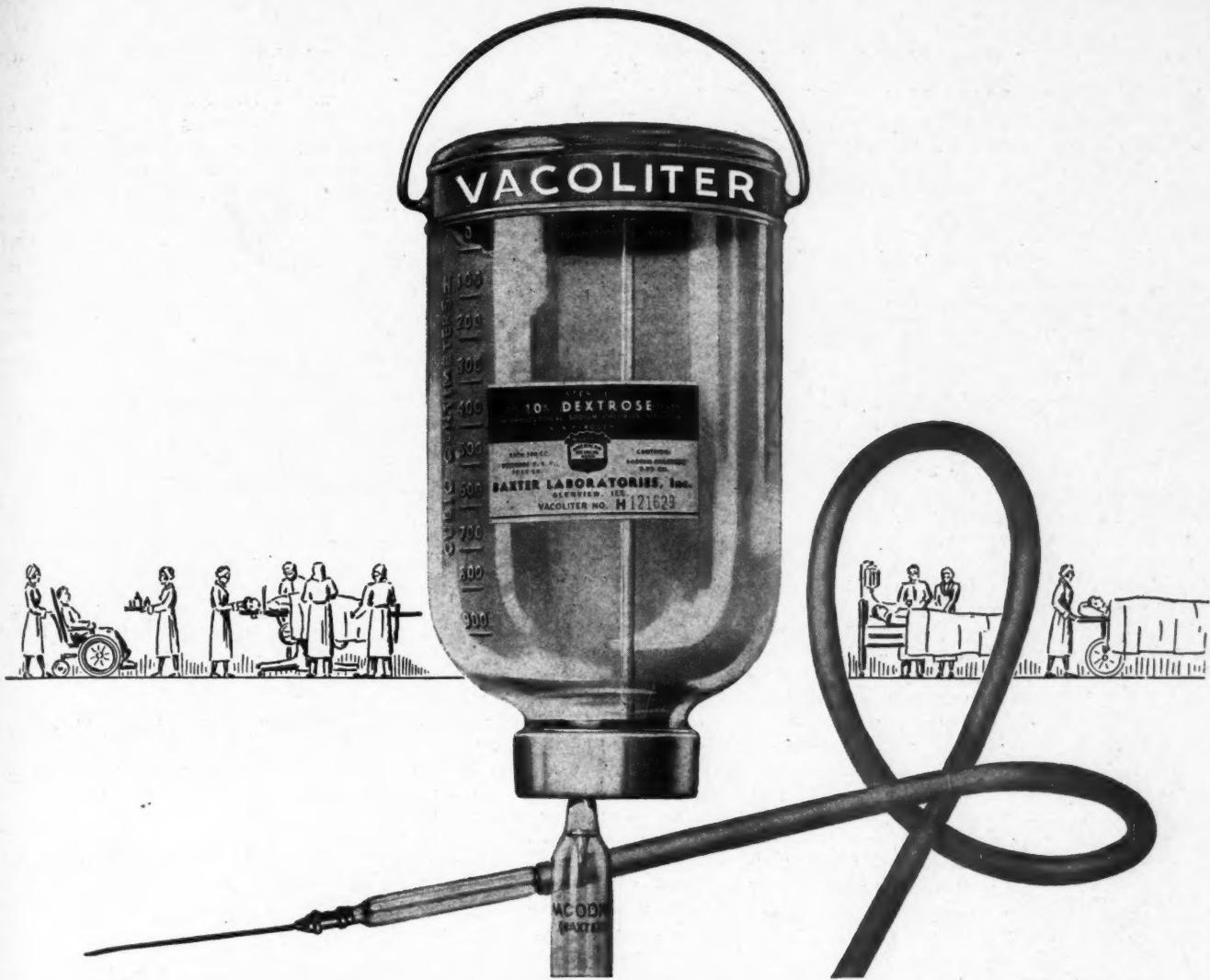
Even with the pre-rinse built into the machine, it has been found that a tiny sink with running hot water for hand use is necessary when eggs or cigarette stains seem likely to withstand the pre-rinse.

The rinse-to-drain and the scald rinse features might easily be added to almost any type of dishwashing machine at small cost and thus add to its efficiency both in regard to quality and quantity of dishwashing. It should be borne in mind, however, that there are complex mechanical problems involved which require careful and skillful engineering.

While it is seldom that epidemics have been spread with improperly washed dishes, since chinaware is a poor medium for the growth of bacteria, the hospital cannot afford to take unnecessary risks.

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The End of the Pests

By Joseph Laferriere

Consulting Entomologist, Boston

WITH the disappearance of the stable, the house fly has ceased to be a city pest of any importance. The garbage can remains its principal breeding place, and if this is kept tightly closed the fly will not find much other warm and fermenting organic matter in which to lay its eggs. When the garbage is taken away twice a week, the maggots have no time to pupate and the flies which like to congregate about the barrels may be killed by frequent spraying.

Commercial fly sprays are expensive because they usually contain Pyrethrum or derris extracts to reach fast flying insects. But all of the fly sprays until 1911 and even many of them today are made without the extracts, like bedbug liquids, with oils within the kerosene fraction, highly refined and perfumed. Since kerosene is a good solvent for the pyrethrins, the extract may be easily made in the hospital laboratory by macerating or soaking 1 pound of Pyrethrum flowers in 1 gallon of kerosene and straining the liquid, which is then added to 8 gallons of kerosene and perfumed with 8 ounces of oil of wintergreen.

A cheaper fly spray for use in the basement and similar places can be made by putting 5 pounds of Pyrethrum flowers in a cheese cloth and soaking in 10 gallons of kerosene and 5 quarts of fuel oil (of the quality 28-32 American Petroleum Institute scale). The liquid may be strained to make it less staining.

Fly Traps and Baits

Fly traps are described in the U. S. Department of Agriculture *Farmers' Bulletin*, No. 734. To be at all effective they should be set out in April and should remain throughout the summer. Arsenic baits are now replaced by a weak solution of formalin. The United States Public Health Service has recommended a 1 per cent solution of sodium salicylate added to milk or sugar syrup. If formalin is used, 2 tablespoonfuls of 40 per cent formalin may be mixed with $\frac{1}{2}$ pint of water. Marcovitch has found a more toxic poison in a saturated solution of sodium fluosilicate (1-154, or 1 tablespoonful in 1 pint of water). This is readily imbibed when no other food or water is present. It can be exposed in shallow dishes near the window when the shades are drawn to darken the room. The treatment then is rapid, because the fly is strongly attracted to light.

Most of the hard work is done now and only a few minor pests remain—the cricket, the mosquito, the fly, the flea. Their extermination will seem almost simple in comparison to the work we've done during the past few months

Permanent control of the mosquito plague can be achieved only by the destruction and treatment of their breeding places. All mosquito larvae are aquatic. A few hours' work on all chance accumulations of water in and about the hospital will go far in permanently exterminating the pests. If the water cannot be removed, it can be screened or treated with a layer of fuel oil or with 2 ounces of borax to every gallon of water, which will prevent the mosquitoes from breeding but will also make the water unfit for drinking.

In their splendid paper in the *Farmers' Bulletin*, No. 1570, Howard and Bishopp have described the innumerable and unsuspected places where mosquitoes will breed: the roof gutters of every building, especially when they are clogged; the fire buckets and water barrels; water in vases and in the pitchers of guest rooms; tanks in water-closets, pipes and washstands; broken bottles on stone walls, and catch basins, which in cities are often the principal breeding place. Such catch basins are commonly placed near street crossings, and their water is removed only by rain or when the street is flushed. The larvae can often mature between rains. The best remedy is to oil the basins near the hospital.

Flea invasions are probably rare enough in hospitals, but when they happen they can present quite a problem. Houses in the Eastern parts of the country suffer more from the cat and dog flea; those of the South and West, from the human flea.

Most house infestations of the cat and dog flea are traceable to basements or outhouses where pet animals stay. According to Bishopp, when comparatively small numbers of these fleas are found on people in houses,

breeding places should be sought out of doors in outhouses frequented by dogs and cats. The eggs adhere so lightly to the host that they fall almost anywhere and the larvae will breed in the refuse on the floor. Breeding will go on unchecked if the house is closed during the summer and soon the rooms will be overrun with the pest.

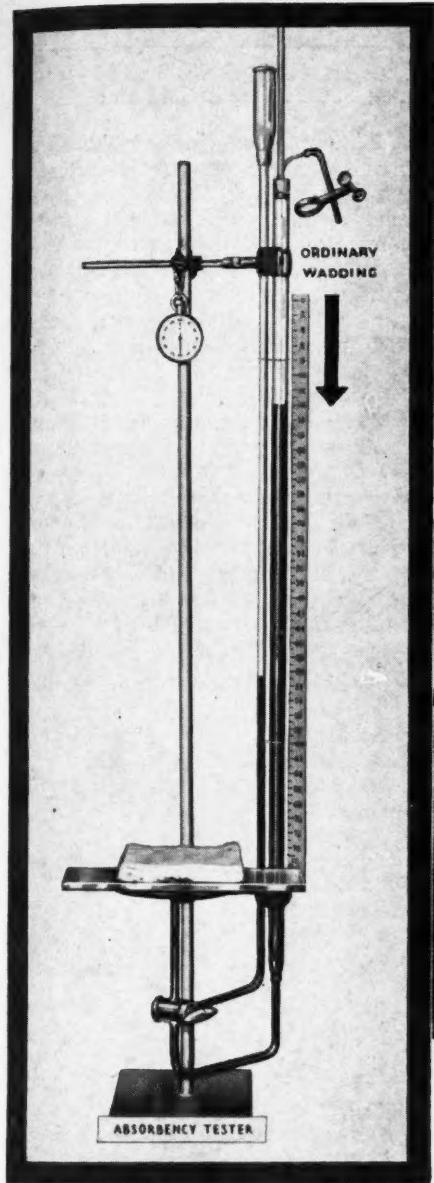
The first remedy is to clean the pets with a flea soap or powder and thoroughly beat and air their sleeping quarters. In some cases the infestation has been known to extend to lawns and even all over the premises, although its center can be traced to a place frequented by the animals. When a basement or outhouse is overrun with fleas, the best method of extermination is to spray them with creosote oil. "A light spraying," says Bishopp, "kills the adult fleas almost instantly and apparently has some destructive effect on the immature stages." Creosote oil, which is used as a wood preservative, costs about fifty cents a gallon.

Controlling the Human Flea

Control in the building is the same for the human flea. The outbreaks of the latter are less severe than those of the dog flea, but the breeding places are more widely extended. Although man is its normal host, the human flea is often found on other mammals. Hogs, for instance, are often badly infested in the Southern and Western states. Its strangest habit is that of breeding in such sandy places as beaches and picnic grounds, which often swarm with the human flea waiting for a chance to feed. The larvae are bred in the sand and feed on organic refuse. Last year, the city hall in a neighboring community was fumigated to destroy a bad outbreak of sand fleas.

When human or dog fleas have invaded a building, the first step, after cleaning the animals and their beds, is to take up the floor coverings to kill the eggs and worms. The floor is carefully swept and the dust burned. Then it is scrubbed with soapsuds or kerosene, or heavily sprayed with the bedbug liquid described in the second article of this series, which appeared in the February issue. Another method is to scatter 5 pounds of flake naphthalene on the floor of an infected room, and close the doors and windows tightly. Skinner found this effective. The next day the flakes may be swept up and scattered in another room, thus making the treatment inexpensive. Paradichlorobenzene is probably as good, but far more costly.

The house cricket, *Gryllus domesticus*, is another household pest. According to most authors, it is more common in Canada. Walker found it in great numbers in the basement of



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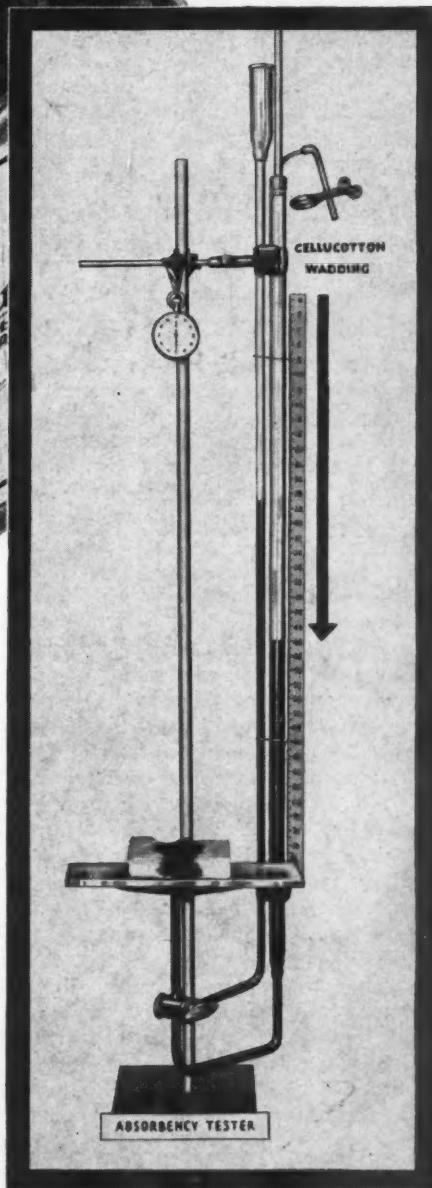
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a Toronto hospital "lurking in the chinks between the bricks of the wall, and positively swarming under the loose bricks close to the furnace." It is found only sparingly in the states east of the Mississippi, and Essig does not even list it among the insects of Western North America. Seldom is it numerous, though in some cases it will multiply and overrun all the floors of a small house. In larger buildings, it usually occurs on the ground floor and in the basement in the furnace or boiler room. It is not destructive, though it will sometimes chew into fabrics.

Sleuthing in the Dark

Nocturnal in its habits, the house cricket can be hunted in the dark with a flashlight and killed with a spray, but it is more easily controlled with a bait. Zappe cleaned out a bad infestation with the following baits: (1) $\frac{1}{2}$ pound potato flour, $\frac{1}{2}$ pound borax and 1 mashed banana, mixed with enough water to make a fine paste; (2) 1 tablet bichloride of mercury dissolved in $\frac{1}{2}$ cup of water, and added to 1 cup of flour to make a paste, in which the skin of a banana is placed. The crickets showed themselves fond of bananas. Two days later the bait was completely eaten and only a few live crickets were seen, which soon succumbed.

The crickets that most often invade houses in most parts of the country belong to the native species. Probably the most common over the whole of the continent is the black field cricket, *Gryllus assimilis*. Whenever this species develops in any number it gradually makes its way to houses. In Quincy, Mass., last summer, there were invasions in four districts coming from near-by dumps. Outbreaks often happen along the Atlantic seaboard and in several Western states. The field cricket has about the same eating habits as the house cricket, but a greater tendency to eat into fabrics.

In general all crickets may be controlled by the baits used against grasshoppers. Munro and Carruth (1932) have recently conducted a series of experiments against the black field cricket. Molasses was found to be the best attractant, and sodium fluosilicate and sodium fluoride proved to be more toxic than white arsenic, Paris green, or thallium sulphate. The bait is composed of 5 pounds bran, 4 ounces sodium fluosilicate or sodium fluoride, 0.5 gallons cane molasses and 0.6 gallons water. Sodium fluoride or insect powder may be dusted in the corners and in every infested place.

A more common and faster growing pest is the silverfish—that pearl-gray insect we so often see passing like a flash when we suddenly move a book or paper. Basement conditions are

particularly adapted to its development, especially in large buildings. According to Back, *Farmers' Bulletin*, No. 1665, the walls of furnace rooms and near-by warm storage places may seem to be swarming with these insects which migrate along the plumbing to the floors above. They may even reach the upper floors. They do not enter with the coal supply as is often believed, but they will develop so rapidly during the summer that in the fall they will be overrunning the coal bin.

In their great craving for starches, silverfish may attack any starched clothing or linens, or even silks and rayons which have been stiffened with sizing. If they bite into carpets or furniture covers, it is to get at the crumbs that are lodged therein. Also they chew through wall paper to get at the paste at the back. But they seldom cause real damage except where they remain undisturbed for a long time.

For the problem of control, see Back, *Farmers' Bulletin*, No. 1665. Silverfish are strongly attracted to baits that contain starch. Back recommends "a thin paste by mixing from $\frac{1}{2}$ to $\frac{3}{4}$ ounce of white arsenic with 1 pint of wheat flour and adding enough water to make a thin paste by boiling. The paste should be poured on small pieces of flexible cardboard or paper which later can be rolled into cylinders with the paste on the inside. The powder or paste should be put in out-of-the-way places where silverfish are found. . . ."

For a powder that is almost as effective as the paste, mix one part of sodium fluoride with 5 to 8 parts of flour (Marcovitch 1933). According to Metcalf and Flint, Spencer obtained good results with 10 parts sodium fluoride and 100 parts flour. Back recommends the same proportion. It is probable that the silverfish really eat the powder. Finally, the insect may be hunted in the dark with a flashlight and destroyed with sprays, like other nocturnal insects.

Another hospital pest is the house centipede, *Scutigera forceps*, a myriapod, about 1 inch long, grayish yellow in color, and with a fringe of 15 pairs of long legs. It is a great devourer of household insects, but most people object to its presence. Seldom is it reported to have bitten human beings, though its bite must be slightly poisonous. It sometimes develops in great numbers. Like the cockroach, it prefers damp places, such as bathrooms, moist closets and cellars, and is abundant in conservatories and wherever pots are stored. Individuals should be destroyed as soon as they appear, and damp places should be often inspected. When they are found in numbers they may be sprayed or dusted with insect powder.

THE HOUSEKEEPER'S CORNER

- The annual meeting of the Connecticut chapter of the National Executive Housekeepers Association, which wound up the year's activities, took the form of a beach party. The first order of the day was the annual election of officers, Blanche I. Newton of Grace Hospital, New Haven, being chosen president; Gertrude F. Page, New Britain Hospital, New Britain, vice president; Evelyn L. Coolidge, New Haven Hospital, New Haven, recording secretary; Catherine M. Mason, Norwalk Hospital, Norwalk, corresponding secretary, and Kathryn Quinn, State Hospital, Norwich, treasurer. With business out of the way the group proceeded to celebrate with a banquet of real New England beans, frankfurters and lobster salad.

- The following interesting figures on the distribution of the hospital dollar between the nursing school, the dietary department and the housekeeping department, revealed by a recent survey of various sized hospitals, were presented by Mrs. Alta M. LaBelle, housekeeper, Michael Reese Hospital, Chicago, at the Tri-State Assembly, held in Chicago.

125-Bed Hospital

| | |
|--------------------|----------|
| Nursing | \$0.1533 |
| Dietary | .0473 |
| Housekeeping | .0800 |

137-Bed Hospital

| | |
|--------------------|----------|
| Nursing | \$0.1695 |
| Dietary | .0559 |
| Housekeeping | .0920 |

225-Bed Hospital

| | |
|--------------------|----------|
| Nursing | \$0.1484 |
| Dietary | .0516 |
| Housekeeping | .0758 |

387-Bed Hospital

| | |
|--------------------|----------|
| Nursing | \$0.1166 |
| Dietary | .1000 |
| Housekeeping | .0750 |

900-Bed Hospital

| | |
|--------------------|----------|
| Nursing | \$0.1463 |
| Dietary | .0523 |
| Housekeeping | .0765 |

- A bigger and better show is promised by the National Hotel Exposition in New York during the week of October 26 to 30. Housekeepers particularly will find much of interest in demonstrations of new cleaning methods and new appliances to cut cleaning costs. Linen, draperies, and furniture exhibits are also promised, representing the latest style trends. The date should be circled now in red—October 26-30, Grand Central Palace, New York.

- Louise Leturc, active in the New York chapter of the National Executive Housekeepers Association and who has been identified with several large New York City hospitals, has assumed the post of matron housekeeper of the Fulton House, Nurses' Home, Bronx Hospital, New York City.

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Inexpensive, easily prepared, it makes patients' days more comfortable

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When sultry summer weather makes

hospital patients uncomfortable, irritable and fretful, let the magic of tea help smooth out their nerves and take their minds off the heat. Serve tea several times a day. It's so easily prepared, so inexpensive, so effective in every way. There is probably nothing else that will do so much to bring a feeling of well-being to those confined to hospital beds during the long, hot days of August.



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Central Food Service in Practice

By J. Marie Melgaard

Formerly Director, Dietary Department, Mount Sinai Hospital,
Philadelphia

THE dietary department of Mount Sinai Hospital, Philadelphia, which occupies three floors in the north wing of the ten-story building, consists of the following divisions: office of the director; general kitchen; therapeutic service, including the special diet kitchen, central nourishment kitchen, nutrition clinic and foods and nutrition classes for student dietitians and student nurses; kosher kitchen; central dishwashing room; employees' cafeteria, and dining rooms.

On the ground floor are the kosher kitchen, employees' cafeteria, central dishwashing room and storerooms for canned goods, staple groceries and such reserve supplies as china, silver and glassware. Directly above, on the first floor, are the general kitchen, special diet kitchen, and central nourishment room. On the second floor are dining rooms for all the hospital staff and nurses. With this vertical arrangement, the food service unit is

compact and also easily accessible.

The kosher kitchen unit was opened in April, 1930, and gives excellent service to patients who upon admittance, have expressed their preference for kosher food. It consists of two separate kitchens, each with its own distinctive and identical equipment for giving service to about fifty patients. One is the "milk kitchen," where two meals a day, breakfast and supper, are prepared and served. The other is the "meat kitchen," which is in use for only one meal a day, dinner at noon. The kosher kitchen is a self-contained unit, preparing, cooking, serving and dishwashing for patients on kosher diets only.

The equipment in each kitchen consists of a two-compartment sink, a range, two steam-jacketed kettles, a steam table with bain-marie, an electric refrigerator, a dishwashing machine with soiled and clean dish tables, dressers for the storage of china and

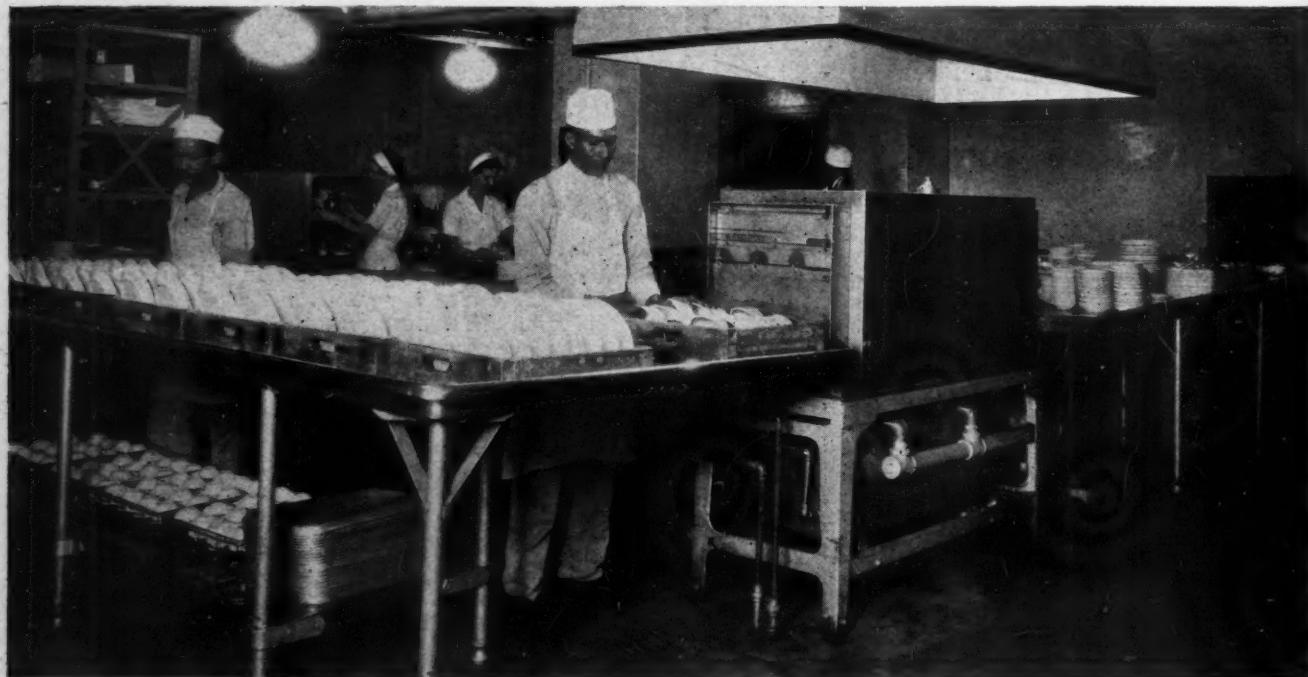
silver, and an insulated food conveyor. All pieces of cooking equipment for each kitchen are distinctly marked so they cannot become mixed. Each kitchen has its own china and silverware pattern, and etched on the handles of the silverware is "milk" or "meat." In the milk kitchen, cooking utensils are marked with small aluminum tags with the word "milk" on them. The utensils in the meat kitchen have brass tags marked "meat."

The Jewish dietary laws and the Jewish holidays are strictly observed even to the Seder at the beginning of Passover. We also have two sets of dishes and utensils stored away, which are used during Passover weeks only.

The employees' cafeteria is a large room with a U-shaped counter in the center between two doors. This counter is a double service unit with two steam tables on both sides. In the center are the coffee urn, butter cutter, milk urn and refrigerator.

The central dishwashing room was established in April, 1933. It is equipped with a monel metal two-tank dishwashing machine with adequate soiled and clean dish monel metal tables and sinks for washing all the china, silverware and glassware. Centralizing all the dishwashing on the ground floor improved the service greatly and eliminated many problems. Trays for patients are set up after the meal and the tray trucks are stored between meals in this room. All the cleaning supplies are kept under lock and key in large closets in this department, and distributed upon requisition.

The general kitchen, with daylight on three sides, has splendid ventilation and lighting. As an aid to ven-



The central dishwashing room is equipped with a monel metal two-tank dishwashing machine and adequate tables.

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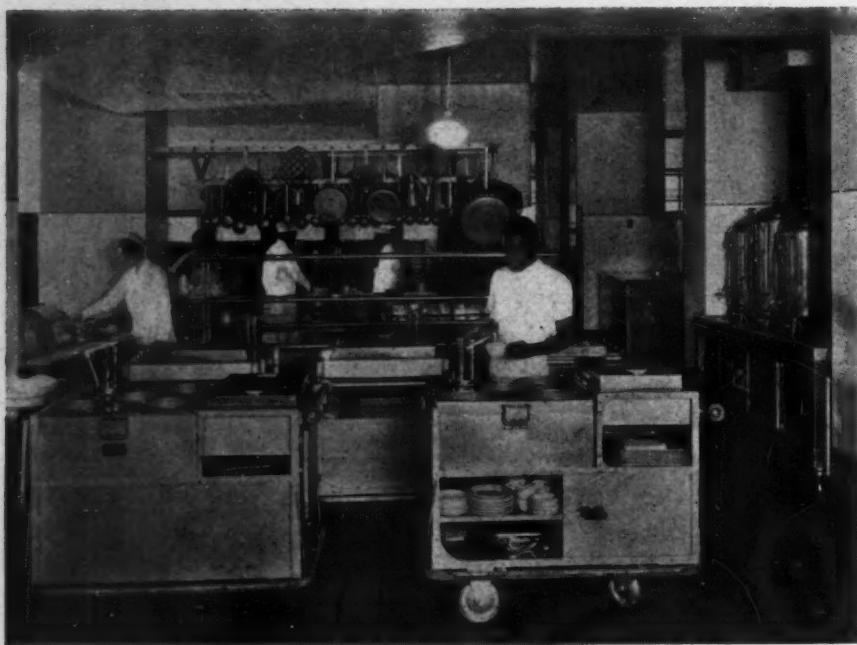
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The general kitchen, with daylight on three sides, has splendid ventilation and lighting. The cooking equipment is placed about halfway between the center and the east wall and is surrounded by steam and work tables.

tilation and lighting, the kitchen has partitions 7 feet high between its various subdivisions, such as the meat shop and bake shop, instead of having a solid wall to the ceiling. The mechanical ventilation over ranges, steamers, urns, and the dishwashing machine, draws off all cooking odors, heat and vapor.

The cooking equipment is placed about halfway between the center of the kitchen and the east wall. It is surrounded by work and steam tables, steam kettles and a compartment steamer. Adjacent to the cooking space are the subdivisions of the kitchen—the meat shop, vegetable room, scullery, bake shop, central service pantry and a storeroom for canned goods and groceries. A few steps away are the special diet kitchen and the central nourishment room.

The arrangement of the various rooms within the kitchen itself and the grouping of the equipment are such that not many unnecessary steps are taken and food service is expedited, with a minimum of time and energy. The raw material is kept moving in one direction from its delivery point. The uncooked meats required for the day are prepared in the meat shop and distributed from there, upon requisition, to the daily supply refrigerators. All the lettuce is prepared in the vegetable room and routed the same way; other raw food materials are treated similarly. Bulk milk goes directly from the dairy refrigerator to the milk urns in the different pantries and is served from them. These urns are well iced and kept locked between meals.

The delivery entrance is conveniently near the kitchen entrance; all

perishable goods are delivered directly to the large refrigerators at this point. All canned and staple groceries are delivered weekly to the large store-rooms on the ground floor. Withdrawals for these supplies are made on requisitions to the storekeeper.

Mechanical refrigeration is provided from the central power plant. We have three large refrigerators for bulk supplies—fruits and vegetables; meats; dairy products—and a fish box. There are three daily supply refrigerators in the general kitchen and one in the special diet kitchen. We make our own ice cream, and the machine is in the power plant.

The special diet kitchen, in close proximity to the general kitchen, is equally well laid out on a smaller scale. All special diets are prepared and served from there. The old dishwashing room is at the present time the central nourishment room.

The dietary department has tray trucks, food conveyors, dish trucks, steel dressers, dishwarmers, coffee urns, bake ovens, pastry tables, pot cabinets, spice cabinets, counters, sinks, butter cutters, milk urns and all the necessary motorized labor saving devices that save on food supplies and facilitate service. Most of the stationary equipment, such as sinks, counters and tables, are constructed of heavy gauge monel metal.

The food is transported to the floors by a service elevator and two dumb-waiters. Another dumb-waiter connects the kitchen with the employees' cafeteria below and the dining rooms above.

There are dining rooms for resident doctors and heads of departments; staff and student nurses; private duty

nurses, and the clerical force. The servery extends along one side with a long cafeteria counter and tray slide so it can be used either for cafeteria or waitress service. Behind the counter are a milk urn, cream urn, butter cutter and steam table. Beyond this is a long table with a toaster, egg boiler, gas hot plate, electric waffle baker and electric griddle. A refrigerator and sink are in one corner and off at the other side is the room for scraping soiled dishes before they are sent to the central dishwashing room.

The dining rooms are tastefully decorated, well lighted and cheerful. They have more of a tea room atmosphere than the average institutional dining room. The table tops are of rubber composition and can be used with or without table cloths.

Our scheme of organization holds the dietitian directly responsible for the entire food service unit and gives her control over all the food problems of the hospital. From the beginning the whole department was planned and organized for central service.

Under the head of the department are four subdivisions, each supervised by an assistant dietitian. The responsibilities and work of these divisions are well defined, but equally important are the coordinated efforts between the assistant dietitians and the personnel to keep the food service going forward with the least possible friction. There is an organization chart in the director's office that shows the four divisions and the grouping of the employees in each one.

The director of the dietary department is directly responsible to the superintendent of the hospital. The duties of the director, for the most part, include the purchasing of all food supplies and equipment, and the direction of the work of the department and its contacts throughout the hospital. Daily conferences are held with the assistant dietitians to make any adjustments or suggestions for the betterment of the service.

Every morning the departmental report for the previous day goes to the superintendent. This is a concise report compiled from the daily reports of the assistant dietitians, giving the menu served to the different groups, census and special diets.

In the director's office are kept all the technical and clinical records of the department. The secretary does all the typewriting and is timekeeper for the department. As the department works on the budget system, a daily record is kept of all food supplies purchased for the day, as a check against the budget. A close check is kept on all foodstuffs so that the incoming, raw material can be compared in a reasonably accurate fashion with the outgoing, finished product.

The administrative dietitian plans all the menus for the house, with the



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Libby's patented method really does give tomato juice a noticeably finer

flavor. From perfect red-ripe tomatoes gentle press takes only the pure sweet juice. Quickly packed, Libby's supplies Vitamins A, B, C and G in a juice that patients prefer.



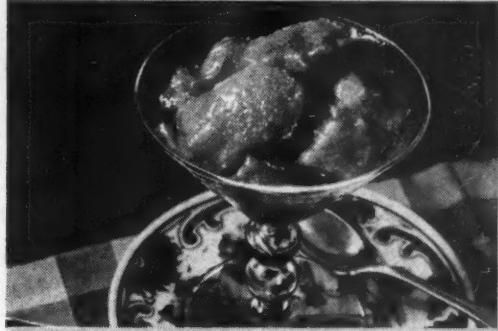
Doctors everywhere are recommending it as a dependably good source of Vitamin C.



Libby's gentle press
(Process patented U. S. 1,956,615)

TOMATO JUICE

Ideas
FROM THE
DIET KITCHENS OF
LEADING HOSPITALS



TOMATO ICE for the Reduction Diet When served with the dinner, simply season Libby's gentle press Tomato Juice, add lemon juice, and freeze. For a dessert, add seedless white grapes.



TOMATO SOUFFLÉ for the Soft Diet To a sauce made of 2 tbsps. flour, 2 tbsps. butter, and $\frac{1}{2}$ tsp. salt, add 2 well-beaten egg yolks and 1 c. Libby's Tomato Juice. Fold in stiffly beaten egg whites and bake in a buttered ramekin in a slow oven (325° F) until firm.



TOMATO-PINEAPPLE JUICE for the Diabetic or Liquid Diet Combine 2 parts Libby's gentle press Tomato Juice with 1 part Libby's Pineapple Juice. Serve very cold.

Libby's 100 Fine Foods include Fruits and Fruit Juices, Vegetables, Pickles, Condiments, Canned Meats, Evaporated Milk, Alaska Salmon. Each comes in regular and special sizes for institutions. In addition, Libby packs Homogenized Foods for Babies.

exception of special diets, and is responsible for the general routine of the department. She supervises the work in the general kitchen, the preparation and distribution of all food and the utilization of left-overs. She requisitions all raw food supplies necessary for the department. She is also responsible for the quantity and quality of these supplies upon delivery. All food supplies are kept under lock and key and are issued, under her direction, to the various divisions within and without the department upon the receipt of properly signed requisitions. She interviews, engages and dismisses employees. She is in

as is possible. She spends at least two hours daily conferring with patients and physicians in the nutrition clinic. She is responsible for the instruction of student nurses in all their theoretical and practical work.

The first assistant dietitian supervises the work in the kosher kitchen, employees' cafeteria and central dishwashing room. She assists the director in checking and keeping the inventories, reserve supplies and linen in order. New china and glassware are issued only upon the receipt of a piece of the broken article. She checks and requisitions groceries and canned goods once a week. Every morning

out a definite apportionment of duties so that a routine is fairly well established. Upon employment, typewritten copies of the routine work are supplied to the personnel, with a copy of the rules and regulations covering their working conditions and behavior. A physical examination is required of employees before they begin work, and thereafter a routine examination is given twice a year. Employees are well uniformed by the hospital, and are proud of their appearance. An accurate check is kept on the employees' time as they have to punch a time clock upon reporting for work in the morning, their hours off in the afternoon and when they leave at night.

Rules and regulations governing the food service have been developed, but they are constantly being improved for the betterment of the service.

Central Service Introduced

Up to six months ago food for ward patients was sent to and served on the ward floors in insulated food conveyors. While this service was satisfactory and we had no complaints, it did not quite come up to our standards of food service and efficiency. So central tray service was established for ward patients, as for private patients, except that ward patients do not have selective menus. All ward and private patients' trays are served directly from the general kitchen where the individual trays are set up as the dietitian calls off the various items from the menus. Only the toast is prepared in the floor service kitchen.

The trays are transported to the floors by large tray trucks. As quickly as a truck is loaded, it is sped to the floor via the service elevator. There tray girls carry the trays to the patients' rooms. After the meal they collect them and take them to the central dishwashing room. Central tray service for ward patients greatly exceeded our expectations; there is less handling of the food and less confusion on the floors at serving time.

The special diet kitchen tray service is the same as that of the general kitchen, except that student nurses in the diet kitchen are responsible for serving the trays.

All nourishments are prepared in the central nourishment room from which they are served both individually and in bulk. Routine nourishments are served to all patients at 10 a.m., and 2 and 7:30 p.m. every day.

In the dining rooms we have cafeteria service for student nurses for breakfast only, and for the clerical force three times a day. All the others have waitress service. Hot food is sent up from the general kitchen in bulk and served from the steam table.



The kosher kitchen unit gives service to patients who upon admittance have expressed their preference for kosher food. It consists of a "milk" kitchen and a "meat" kitchen, each of which has its own equipment.

charge of the department during the absence of the director.

The second assistant dietitian assists the administrative dietitian in the supervision of the general kitchen. She is directly responsible for the central tray service to private, semiprivate and ward patients. As private patients have selective menus, she goes up to the private floors every morning and checks over the following day's menu with every patient, insofar as is possible. This contact is most satisfactory and reduces complaints to a minimum. She requisitions and checks food supplies for the central tray service. She also relieves in the nutrition clinic when necessary.

The therapeutic dietitian and instructor in dietetics is responsible for the special diet kitchen and the central nourishment service. She prepares all the menus for patients on special diets. She keeps a close check on her patients, instructing them regarding their diets, and making rounds with the physicians as much

she calls for quotations on food prices, and these in turn are checked by the director before the provisions are ordered. She is responsible for the purchase of all fresh fruits and vegetables, and for this purpose makes a visit to the markets twice a week.

The dining room manager is responsible for the serving of all food, for cleanliness, order, inventories and care of the linen in the dining rooms. She is also responsible for the care and cleanliness of the employees' rest rooms and the weekly inspection of lockers.

Once a week each dietitian takes a complete inventory of all the china, silverware and glassware used in her own department. All breakage must be listed and charged to the employee. Any new requests must be accompanied by strong reason for their necessity.

The work of the personnel has been standardized by outlining the work to be done by each employee. We have tried to analyze each job and work

GLYCINE of GELATINE in MUSCULAR DYSTROPHY

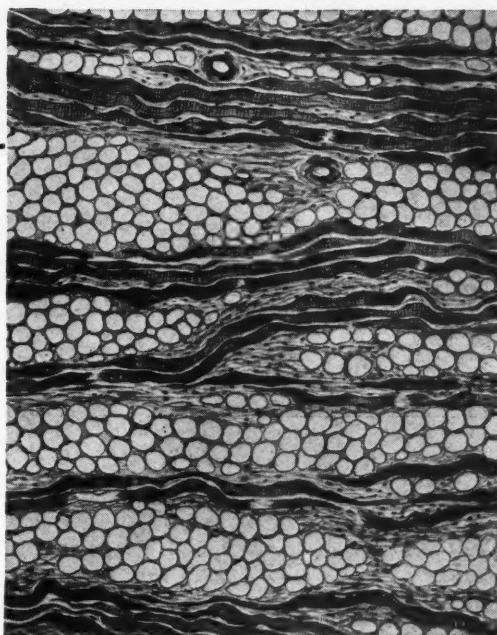
• Since 1932 observers have been reporting improvement in patients with muscular dystrophies who have been fed glycine daily over a period of weeks. Among the types of cases that have definitely been benefited are those of myasthenia gravis, pseudohypertrophic muscular dystrophy, and progressive muscular dystrophy. (1)

Benefits have ranged from arrest of the disease and the cessation of symptoms to improved muscle function and a return toward normal striations. For instance, one report by Boothby on 46 cases of myasthenia gravis states that all but two responded favorably. (2)

Knox Gelatine is 25% glycine and is an inexpensive adjuvant in glycine therapy. The recommended dosage of 10 to 15 grams of glycine daily is contained in 40 to 60 grams of Knox Gelatine. As high as 3½% of Knox Gelatine can be used in desserts and 10% in soups Knox Gelatine, made as carefully as an ampule solution, contains no sugar or flavoring; pH about 6.0; bacteriologically safe.

(1) Tripoli, McCord & Beard, J.A.M.A. Nov. 24, 1934.

(2) W. M. Boothby, Arch. Int. Med. 53, 39-45.



Muscular atrophy in progressive dystrophy. Note infiltration of fat and both swollen and shrunken muscle fibres: striation obliterated.

Note to Hospital Supply Buyers

• Knox Sparkling Gelatine is economical—one ounce makes 4 pints. Knox Plain Sparkling Gelatine and Knox Jell, the quality, ready-flavored dessert in six delicious flavors, cost approximately the same as inferior varieties which are not as pure nor as scientifically made. Why not insist on Knox when you order?

Send for booklet of recipes showing how gelatine may be used to make interesting glycine-rich dishes.

SPARKLING KNOX GELATINE

KNOX GELATINE LABORATORIES, 465 Knox Avenue, Johnstown, N. Y.

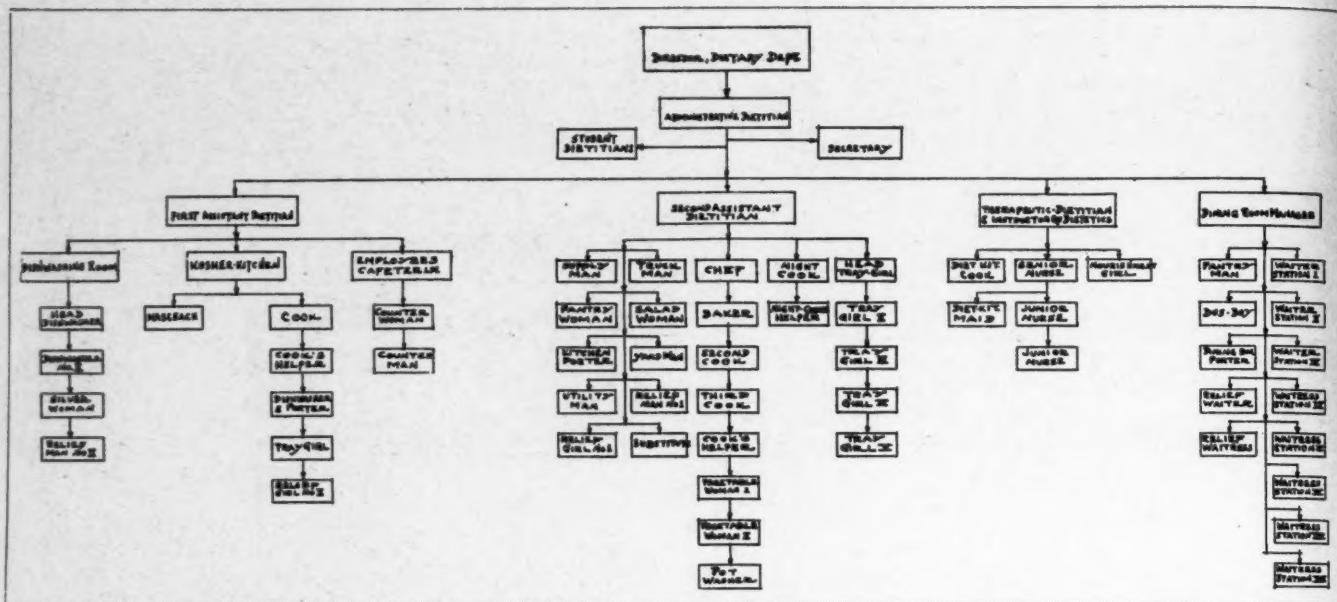
Please send me your new booklet "Glycine Therapy in Muscular Dystrophy and Myasthenia Gravis."

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Street and Number.....

City..... State.....





Organization chart of the dietary department of Mount Sinai Hospital, Philadelphia.

Cold foods, such as salads and desserts, are sent up in individual dishes on large trays from the central service pantry. Only the coffee and toast are prepared in the servery. Waffles and griddle cakes are served directly from the waffle baker and hot plate. When more food is required the order goes to the general kitchen via the automatic telephone. We feed on the average about two hundred persons three meals a day.

The serving of food in the employees' cafeteria is similar to that in the dining rooms, but is self-service entirely. Altogether we feed about one hundred and fifty employees three times a day.

The night cook and her helper prepare and serve the night lunch at 11 p.m. to about fifty persons. Two small dining rooms on the second floor are open at night, one for nurses and the other for orderlies. This is all self-service.

The number of people served in the dining rooms and the employees' cafeteria are checked against the daily census slips from each department head. These reports are sent to the director's office every morning.

Garbage Is Weighed

Food waste is being reduced to a minimum through a watch kept on the garbage and what is returned on trays and in the dining rooms. The garbage is weighed after each meal and its weight recorded. This has been done consistently so that it has become a matter of routine. Pilfering is almost nil as everything is kept under lock and key as much as possible and all employees are checked as they leave at night.

Purchasing policies are guided by the budget. All food supplies are carefully inspected and weighed at the delivery entrance before they are ac-

cepted by the dietitian. Supplies are bought on a competitive basis in the open market. Every item to be purchased must have a quotation price from at least two dealers. Canned fruits and vegetables, tea and all paper supplies are bought on yearly contracts.

We find that visits to the markets to buy fresh fruits and vegetables effect a great economy. Purchasing studies are made to standardize each product as to quantity, quality, weight and appearance. Through forms and records comparative analyses of the raw food materials purchased are made by the accounting department to determine the monthly unit food costs. Studies have been made for the standardization of all food servings and basic recipes developed for use in the kitchen and bake shop.

Offers Broad Training

Our educational program is extensive and embraces every phase of the hospital's food service and food problems. Student dietitians and student nurses receive their theoretical and practical training in the kitchens, laboratories and classrooms. The nutrition clinic was established two years ago to aid in educating both in-patients and out-patients. That patients derive great benefit from instruction regarding their diets and the follow-up work after their departure from the hospital has been proved, for the results of their care in the hospital are more lasting. To maintain the good health and morale of staff, nurses and employees by serving them good, wholesome food and teaching them the proper dietetic principles of healthful living is the department's responsibility.

Our central food service unit has been developed gradually over a ten-

year period. It has proved economical, efficient and practical from the stand-point of the patient, the hospital and the staff. The central service idea has avoided much duplication of equipment, work and personnel, which, in turn, has led to better control over supplies and uniformity of preparation, distribution, and service of food to the patient.

Far From Ideal

The *Journal of the American Medical Association* comments as follows on the Copeland Food, Drug, Therapeutic Device and Cosmetic Bill:

"The bill first introduced has been subjected to a sort of plastic surgery in the legislative operating rooms which has resulted in a specimen not even resembling the original model and utterly deficient in many particulars.

"Formulas under this bill are secret and filed with the Department of Agriculture. Violations must be carried from the department into the Federal Trade Commission and the procedure is so long and wearisome and the penalties are so inadequate that the forces of quackdom may ravage the sick and ailing and retire with their booty long before the processes of investigation and prosecution catch up with them."

The article further states that the bill being so far from ideal might well be scrapped and a new beginning made when a better opportunity offers. Perhaps an amending and strengthening of the original bill to cover advertising and the control of the cosmetic industry would do more to protect the uninformed customer than the one which is under consideration at the present time.

Here it is in Black and White, Doctor

More loudly than pages of words which you have no time to read—these few figures will tell you why you will want to say "Ralston" when you're recommending cereal for children and adults.

| | % Protein | % Fat | % Carbo-hy-drates | % Ash | % Calcium | % Phos-phorus | % Iron | Calories per lb. | Vitamin B, Sher-man Units per lb. |
|---------------|-----------|-------|-------------------|-------|-----------|---------------|--------|------------------|-----------------------------------|
| Ralston | 14.2 | 2.0 | 72.0 | 1.6 | .04 | .006 | .004 | 1638 | 2724 |
| Wheat flakes | 13.0 | 1.4 | 74.0 | 2.2 | .05 | .37 | .005 | 1600 | Destroyed by toasting |
| Farina | 11.0 | 1.4 | 76.0 | 0.4 | .02 | .13 | .0008 | 1634 | Too lit-tle to measure |
| Corn flakes | 8.0 | .4 | 87.0 | 3.0 | .02 | .12 | .0009 | 1737 | Destroyed by toasting |
| Rolled oats | 16.0 | 6.0 | 68.0 | 1.9 | .06 | .42 | .004 | 1797 | 1100 |
| Rice, (white) | 8.0 | 0.3 | 79.0 | 0.4 | .01 | .10 | .0009 | 1589 | None |

Best of All . . .

The chart tells you at a glance that Ralston, enriched with extra wheat germ, is consistently high in essential nutritive values, much richer in vitamin B than other commonly used cereals. What it *can't* tell you is how much whole families enjoy eating this hearty golden cereal with the rich, tempting flavor of choice whole wheat. Moreover, Ralston cooks quickly—costs less than one-half cent for a generous serving. For Laboratory Research Report and samples of Ralston Wheat Cereal use the coupon below.

RALSTON PURINA COMPANY, Dept. MH, 141 Checkerboard Square, Saint Louis, Missouri

Please send me a copy of your Research Laboratory Report and samples of "double-rich" Ralston Wheat Cereal.

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(This offer limited to residents of the United States)



Treating Toxic Goiter Through Diet

By Arnold Minnig, M.D.
Denver

AS WE study the diet necessary in the treatment of the symptom complex which we shall designate as Graves' disease or Basedow's disease in honor of two pioneers who early described it, we find there has been uniformity of opinion during the past twenty-five years. Even twenty-five years ago Dr. William Hanna Thompson, professor of nervous diseases at New York University, told the effect of diet in a serious and ultimately fatal case of Graves' disease.

After every remedy ordinarily prescribed for this disease had been tried without success, the patient began to improve until she apparently recovered on being restricted to the use of fermented milk instead of meat. She then resumed eating meat and promptly relapsed. Discontinuing the meat and resuming milk she rapidly improved again. Later she refused to continue the use of milk and returned to meat, with the result that her malady became uncontrollable and soon ended in death.

The dependence of the entire train of symptoms of Graves' disease on what is ingested in the alimentary canal may be experimentally tested at any time. Let a patient with a temporary improvement in the symptoms partake heartily of beef, particularly at night, and immediate relapse will occur. Every one of the characteristic complaints will be aggravated.

It is always advisable to impress upon patients in the beginning that their malady is not easy to cure and that they will have to continue the course of treatment for at least two years.

Not an uncommon symptom of Graves' disease is diarrhea. Any diarrhea, for example, whatever its cause, which has lasted two years cannot be expected to cease without prolonged attention to dietetic rules. Hence, in any disease characterized by as many different disorders as Graves' disease, nothing short of the utmost perseverance in a systematic course of treatment will ensure ultimate recovery. I have always found that relapses occur only after patients have violated instructions in diet and rest.

My routine, after I have made a diagnosis, is to put the patient to bed for six weeks on a milk diet. To this I allow buttermilk to be added. A goodly proportion of patients object to a milk diet. They may say milk disagrees with them. Most of these cases have a hypo-acidity and here I

give dilute hydrochloric acid or permit them to suck half a lemon either before or after the milk. When they get tired of lemons I may add orange juice or grapefruit juice without sugar.

You will observe that I institute the treatment with bed rest. This is important for its effect on the al-

RECIPES BY REQUEST

Submitted by
Helen E. Gilson
Dietitian, Pennsylvania Hospital,
Philadelphia

Shredded Wheat Rolls (34 rolls)

4 shredded wheat biscuits
½ cup molasses
2 tablespoons fat
2 teaspoons salt
2 tablespoons sugar
4 cups liquid (½ hot milk,
½ hot water)
10 cups flour
2 yeast cakes

Soak biscuits in hot liquid, add sugar, lard and salt. When lukewarm add dissolved yeast cakes and flour. Let rise twice, form into rolls and bake.

Spanish Tongue

1 beef tongue
1 cup canned tomatoes
1 cup water
1 small onion
Salt
Pepper
¼ cup vinegar

Scrub tongue (if a salted tongue is used it should soak overnight) and put on to boil in plenty of water. A fresh tongue should be boiled in salted water and a quarter of a cup of good vinegar should be added whether the tongue is salted or fresh. Do not let water actually boil. Simmer from 2 to 4 hours, according to the size of tongue. Let cool in water in which it cooked. Remove skin and trim root end of tongue. Sprinkle with salt and pepper and place in a large casserole. Mix tomatoes, water and minced onion and pour around the tongue. Cover and bake 2 hours in very slow oven. If desired, pared potatoes may be placed in pan ¾ hour before the meat is done. When meat is done remove to hot platter. Melt 2 tablespoons butter in a sauce pan, blend with 2 tablespoons flour and slowly stir in 1 cup water. Add it to the essence in the pan in which tongue cooked. Stir and cook until smooth and thick.

ways damaged and overworked heart and also on the shattered nervous system. An individual who has Graves' disease, I often tell my patients, is more nervous than most people in mental hospitals.

After the patient has been on milk for a six-weeks' period, I gradually add one more article of diet to test him for a possible food sensitiveness. I do this even if I have tested the patient with the skin tests for foods. I usually add cream of wheat to the milk diet first, to be followed by more milk products such as ordinary cheeses, cottage cheese, butter, malted milk, milk puddings. Then eggs, gelatin, and finally vegetables and cooked fruits are added. I keep my patient on this diet through the entire course of treatment.

One German authority gives us what he calls the protective diet in thyroid dysfunction. It is similar to ours, but because it varies a little I will give it here.

The Protective Diet

It consists of avoiding all sorts of meat, white and red, sausages, ham, poultry, fish, meat soups, except very thin meat extracts. Strong tea and coffee are forbidden. Smoking and alcohol are avoided. Articles permitted are: pure fats, even of animal origin, margarine, eggs and egg dishes, liver, sweetbreads, vegetables of all sorts prepared with plenty of butter or cream, fresh or cooked fruit, bread, macaroni, spaghetti, soup dishes, rice, barley, sago, cream puddings, rolls, chocolate, butter and honey. Raw foods, in salads, for example, are permitted also, as well as milk and all its products.

Kletz¹ thinks that the diet in thyrotoxicosis should be rich in carbohydrates, including honey and glucose. In the crises he gives glucose intravenously with good results. He calls his diet the basic diet; it is as follows:

6:00 a.m. Oatmeal porridge, with ½ ounce cream and two teaspoonfuls sugar; tea, with 1 ounce milk; ¼ ounce butter; 1 ounce honey or jam; white bread; fruit—bananas, grapes, prunes, pears, apples and oranges.

8:00 a.m. 6 ounces malted milk; 2 slices bread; ½ ounce honey.

10:00 a.m. 8 ounces milk with one beaten egg and two teaspoonfuls sugar.

12:00 noon. 2 ounces underdone beef, sweetbreads, chicken, rabbit; 6 ounces potatoes, peas, parsnips, turnips, carrots; 2 slices bread; 6 ounces milk; 4 ounces milk pudding.

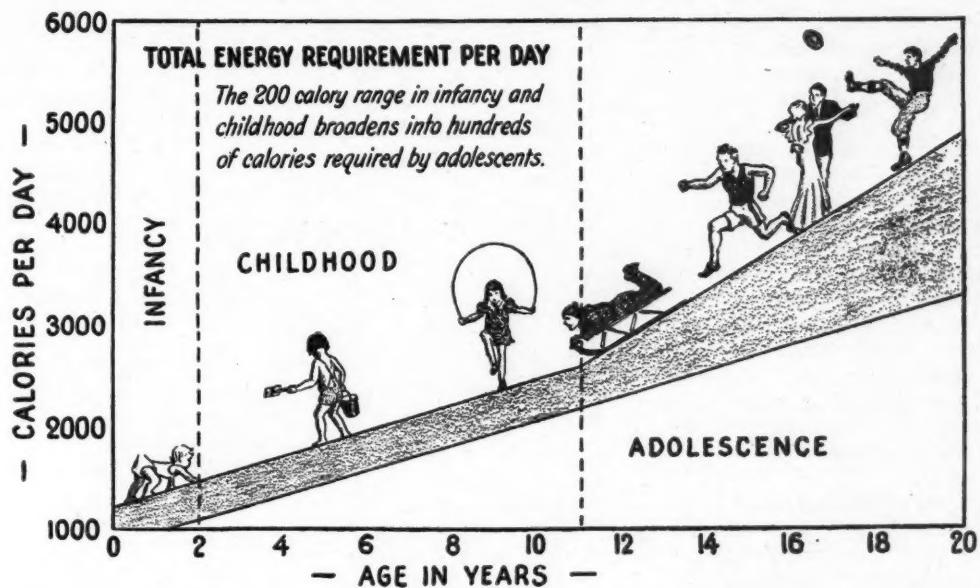
4:00 p.m. Dextrimaltose; milk.

6:00 p.m. Same as breakfast, but no porridge.

Before Bed: Glass of malted milk, two biscuits and ½ ounce butter.

¹Kletz, Norman: Carbohydrate in Relation to the Treatment of Thyrotoxicosis. *The Lancet*, 225:1024 (Nov. 4), 1938.

ADOLESCENT EXHAUSTION *relieved by* CALORIES NOT REST



NORMAL ADOLESCENT boys and girls frequently complain of fatigue. They feel weak and irritable; they show a diminished ability to concentrate; they are disinclined to work; they are physically inefficient.

Some of these symptoms are physiological manifestations of adolescent development. But on careful study many young folks do not consume enough food to provide them with the enormous energy requirements necessary during this transitional period. The symptoms are the consequence of undernutrition.

The graph reveals the sudden rise in caloric requirement during adolescence. Three hurried meals are usually insufficient to provide the tremendous caloric needs. Ac-

cessory meals, mid-morning and mid-afternoon, in certain instances, may be prescribed with advantage. And Karo added to foods and fluids can increase calories as needed. A tablespoon of Karo yields 60 calories. It consists of palatable dextrins, maltose and dextrose (with a small percentage of sucrose added for flavor).

Karo is well-tolerated, highly digestible, not readily fermentable, effectively utilized and inexpensive.

Corn Products Consulting Service for Physicians is available for further clinical information regarding Karo. Please Address: Corn Products Sales Company, Dept. H-8, 17 Battery Place, New York City.



In any illness food must be daintily served, but in this disease it is most important for two reasons: first, the caloric requirement is high; second, the patient is nervous and consequently more particular.

Any tendency toward constipation must be corrected at once. If some of the foods cause flatulence these must, of course, be avoided.

The tachycardia, nervousness, dyspepsia, diarrhea, insomnia, emaciation and weakness do not respond to symptomatic medication.

Metabolism Is High

The metabolism is greatly increased in Graves' disease. A patient at rest has the requirements of a person at hard labor, because he needs one and one-half times as much food as the ordinary person. As a consequence, an excessive appetite without gain in weight and often accompanied by progressive loss in weight is characteristic of the disease. Even a small individual may require as high as 4,000 to 5,000 calories daily.

Gastro-intestinal crises of nausea, vomiting and diarrhea are not uncommon in this disease. As a result the patient is able to retain little nourishment. At such times the loss of weight is rapid and the emaciation becomes marked. If once initiated, these crises are practically uncontrollable. They may show a tendency to be self-limited, if not, they may continue more or less intermittently until death.

When the basal metabolism returns to normal, the first meat added is bacon, which can be given even before the rate has dropped to normal. I am unable to explain this, but it works. Then stewed chicken may be added and baked fish, preferably fresh fish. Everyone is agreed that coffee, tea, pastries, meats, anything fried, condiments must be avoided.

There are certain other things which must be taken into consideration besides the diet. A patient who does not care to give up the use of tobacco does not get along. There is just no use wasting time with such an individual.

Curiously, thyroid patients cannot tolerate liquor. This is fortunate because they must be absolutely denied any form of alcohol.

Another precaution that must not be overlooked is the fact that these patients do not tolerate the sun. They must be kept out of the sun and yet there is a certain group of faddists who prescribe heliotherapy. It is dangerous.

Patients must be watched over a period of two to four years before they can be discharged. They should be checked at regular intervals because the thyroid sick patient has a hereditary tendency. He is predis-

posed to the disease. One not predisposed will never succumb to this malady. He who does not have, shall we say, the thyroid "taint," can even take thyroid extract over quite a period without any ill effects.

The things the thyroid patient must be on his guard against are sudden shock, prolonged discord or domestic upsets. Focal infections must be removed.

Once every week I prescribe two grains of calomel. This I designate on a certain night, for example, every Tuesday. I have wonderful success with this remedy, so much so that I have many times considered seriously the gastro-intestinal origin of the disease. This has been considered in the etiology of thyroid disease by many students.

I have mentioned that hydrochloric acid is often necessary. Another invaluable adjunct that may be necessary is bile salts.

The next and most important thing I want to call to your attention is that the Germans have given us a new and most powerful—I can almost say, miraculous—treatment with certain foreign proteins, namely, animal blood. With this I have been able to cut down the time of treatment materially.

In my practice I have found no necessity for surgery. I predict that in ten years there will not be many thyroidectomies for the reasons given above. We have not removed the cause when the thyroid gland is taken out.

¹Read at the meeting of the Mid-West Hospital Association, Colorado Springs, Colo.

A New Use for Insulin

A new use for insulin in cases of hyperinsulinism was reported by Dr. Henry J. John, Cleveland, at the meeting of the Association for the Study of Internal Secretions. This use is certainly paradoxical, as this disease, known as "hunger disease," is the exact opposite of diabetes.

Foods start the production of insulin in the pancreas, and in this disease the pancreas continues to produce insulin long after there is need for it. Doctor John's method of treatment is to give insulin after the meal, but before the pancreas has been stimulated by the food intake, thus putting the pancreas "to sleep," rather than stimulating the production of insulin. After a period of three months, the condition seems to be permanently relieved.

The theory of this sounds much like the theory that has been brought out by some doctors in the case of hyperacidity. They give hydrochloric acid preceding the meal, in such cases, thus reducing the flow of hydrochloric acid into the stomach.

FOOD FOR THOUGHT

• The problem of handling meals for guests is always an interesting one. Here is presented the method of handling this problem at the Children's Hospital, Cincinnati, by Eva N. Ylvaker.

A small guest dining room is maintained, the purpose of which is to provide a convenient place for the parent or friend to eat who accompanies the child to the hospital. The menu served in the professional dining rooms is used. All meals in this dining room are \$0.50; one sent to a room is \$0.75. For anyone desiring only coffee, cream, sugar and orange juice, a charge of \$0.25 is made, with toast \$0.35. In order to check more accurately with the bookkeeper, a form is found helpful. On it are spaces for listing the floor, date, breakfast, lunch, dinner and special orders for trays for parents or guests. These forms are kept in the special diet kitchen where the trays are prepared. At the end of the day they are turned into the dietitian's office, signed and sent to the accounting department.

• At Glen Lake Sanatorium, Minneapolis, the patients' guests pay for their meals in the patients' dining room—trays are never served to them as visiting hours are over before meals are served.

Another interesting item that comes from Glen Lake Sanatorium is that there are metal or wood strips in the lavatories in every unit where there is handling of food, on which to hang individual nail brushes, each marked with the name of an employee.

• Gertrude Brown, St. Luke's Hospital, Richmond, Va., gives a practical suggestion for saving money. She says that to avoid unnecessary left-overs, rounds are made after the serving of each meal at the ranges, the personnel serving units and the patients' serving units. The amounts prepared are checked against the amounts eaten so that closer buying may be carried out and no undue excess prepared.

• For those who are contemplating the purchase of new silver, a booklet has been prepared which shows a number of very attractive patterns and pictures of the important processes in the making of hospital silver as well as a number of articles designed especially for the hospital tray. This booklet is put out by the Gorham Company, hospital division.

• Dr. Williams McKim Marriott's book on "Infant Feeding" has been revised. The chapter on vitamins has been rewritten and a chapter on allergy has been added and much of the material which was in the first edition has been condensed. Anyone who knows of Doctor Marriott's work knows that such a book is a sound and generally accepted text for the field of pediatrics.

VITAMINS IN CANNED FOODS

II. VITAMIN D

• One of the most interesting chapters in the history of the science of nutrition is that relating to vitamin D. It is a record of steady advances in our knowledge concerning the vitamin. Starting with the work of Huldschinsky in 1919 on the ultraviolet irradiation of rachitic children; passing to the classical discovery in 1924 by Steenbock (1) and by Hess (2) that irradiated foods may acquire antirachitic potency; and extending through the profound studies of Windaus (3) and other investigators, on the constitution of the pure vitamin D obtained by ultraviolet irradiation of ergosterol, the story of vitamin D is a story of steady, scientific progress.

As a result of these basic contributions, there are available today a number of excellent standardized carriers of vitamin D. Viosterol, and the fish liver oils, and their concentrates, are readily available for use in the campaign against rickets whose prevalence, especially among infants in large urban centers, still remains high. In addition to these vitamin D carriers, the vitamin D fortified or irradiated foods have appeared within recent years.

It has become increasingly evident that there are a number of compounds which may promote calcification in the various animal species. It is further evident that these compounds vary in their physiologic

efficiency with various animal species, or that they are "species specific". A number of forms of vitamin D have been postulated (4) and much research in the vitamin D field has been directed toward their isolation and identification.

In general, natural foods have never been regarded as important sources of vitamin D. The commonest food articles show extremely low antirachitic potencies when measured by conventional methods. However, recent evidence has been offered that the contribution of vitamin D made by a varied diet of canned foods may be more significant than has heretofore been supposed (5). While common foods admittedly cannot supply the high demands of infancy and childhood or other phases of the life cycle, for vitamin D, it would appear that they may supply significant amounts of the vitamin to the diet, especially in the case of the adult human, concerning whose quantitative vitamin D requirement comparatively little is known.

Biological research has shown that canned marine products such as salmon, shrimp, and oysters (6) make a small but definite contribution of the antirachitic factor to the diet. We desire to direct the attention of our readers to these interesting facts about canned foods in general, and these canned marine products in particular.

AMERICAN CAN COMPANY

230 Park Avenue, New York City

(1) 1924. J. Biol. Chem. 81, 405
(2) 1924. J. Biol. Chem. 82, 301
(3) 1932. J. Am. Med. Assn. 100, 159
(4) 1932. Physiological Reviews 15, 1-97

(5) 1934. Ind. Eng. Chem. 26, 758
(6) 1935. J. Home Econ. 27, 658
b. 1933. Science 75, 368
c. 1926. Wis. Agr. Expt. Sta. Bul. 388, 124

This is the fifteenth in a series of monthly articles, which will summarize, for your convenience, the conclusions about canned foods which authorities in nutritional research have reached. We want to make this series valuable to you, and so we ask your help. Will you tell us on a post card addressed to the American Can Company, New York, N. Y., what phases of canned foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles.



The Seal of Acceptance denotes that the statements in this advertisement are acceptable to the Committee on Foods of the American Medical Association.

September Dinner Menus for the Staff*

By Elizabeth Hayward

Dietitian, Las Encinas Sanitarium, Pasadena, Calif.

| Day | Soup or Cocktail | Meat or Substitute | Potato or Substitute | Vegetable | Salad or Relish | Dessert |
|-------------------------------------|---|------------------------------|--|--|---|---------|
| 1. A B C Soup | Minute Steak | Baked Potato | Eggplant Soufflé Swiss Chard | Orange and Coconut Salad | Apple Betty, Raisin Sauce | |
| 2. Tomato Bisque | Roast Turkey With Gravy, Jelly | Mashed Potatoes | Asparagus Baked Squash | Lettuce, Roquefort Dressing | Nectarines, Grapes, Plums | |
| 3. Vegetable Soup | Baked Ham, Raisin Sauce | Candied Sweet Potatoes | Mashed Rutabagas Artichoke | Peach Salad | Prune Whip, Custard Sauce | |
| 4. Mulligatawny Soup | Fish | O'Brien Potatoes | Crook Neck Squash | Poinsettia Salad (With White Asparagus) | Fresh Pineapple and Strawberry Cup, Cake | |
| 5. Bouillon, Crackers | Chops | Mashed Potatoes | Carrots and Celery Spinach | Fresh Fruit Salad | Cottage Pudding, Lemon Sauce | |
| 6. Manhattan Soup | Assorted Sandwich Plate With Iced Chocolate Malted Milk | | Okra and Tomatoes | Sugar Plum Salad | Raspberry Ice | |
| 7. Vegetable Soup | Roast Lamb | Parsley Buttered Potatoes | Spinach Wax Beans | Lettuce, Thousand Island Dressing | Fruit Gelatin, Whipped Cream | |
| 8. A B C Soup | Roast Beef | Baked Potato | Crook Neck Squash Asparagus | Fruit Salad | Charlotte Russe | |
| 9. Vegetable Soup | Chops | Creamed Potatoes | Spinach Baked Squash | Pineapple and Date Salad | Apple Snow | |
| 10. Mock Turtle Soup | Chicken Pie | Mashed Potatoes | Spinach Loaf Beets | Edgewater Beach Salad | Stanford Prune Cake, Whipped Cream | |
| 11. Chicken Gumbo Soup | Roast Lamb | Rice au Gratin | Beet Greens | Princess Salad | Fresh Fruit Cup, Cookies | |
| 12. Crab and Tomato Bisque | Fish | Creamed Potatoes | Crook Neck Squash Baked Eggplant | Lettuce and Orange Salad | Rice Dainty | |
| 13. Fruit Cocktail | Sausage With Baked Grits and Syrup | | Swiss Chard With Egg | Sliced Tomato Salad | Fresh Pears | |
| 14. Consommé | Fillet Steak | Baked Potato | Summer Squash au Gratin, String Beans | Mandarin and Grape Salad | Chocolate Bavarian | |
| 15. Purée of Split Pea Soup | Minute Steak | Browned Potatoes | Summer Squash au Gratin, Spinach | Fresh Apple and Pear Salad, Golden Dressing | Lemon Snow, Custard Sauce | |
| 16. Rice Broth | Roast Turkey With Dressing and Gravy, Cranberry Jelly | Mashed Potatoes | Asparagus Oyster Plant | Celery Hearts and Olives | Fresh Sliced Peaches, Arrowroot Crackers | |
| 17. Consommé | Roast Beef | Baked Potato | String Beans Mashed Turnips | Orange and Avocado Salad | Prune Whip | |
| 18. Chowder | Fish | Escalloped Potatoes | Cauliflower Peas and Celery | Frozen Fruit Salad | Cottage Pudding, Sauce | |
| 19. Okra and Tomato Soup | Lamb Chops | Creamed Potatoes | Broiled Carrots Artichoke Soufflé | Mint Apple Salad | Caramel Cornstarch | |
| 20. Cream of Mushroom Soup | Assorted Sandwiches | | Escalloped Zucchini Artichoke Soufflé | Fresh Fruit Salad | Banana Cream Cake | |
| 21. Vegetable Soup | Roast Lamb, Mint Sauce | Mashed Potatoes | Baked Eggplant String Beans | Lettuce Hearts | Nectarines | |
| 22. Split Pea and Vegetable Soup | Lamb Chops | Natural Rice | Beets Oyster Plant | Pineapple and Marshmallow Salad | Lemon Snow, Custard Sauce | |
| 23. Broth With Rice | Chicken Pie, Crab Apples | Mashed Potatoes | Carrots Baked Eggplant | Lettuce Hearts | Assorted Grapes | |
| 24. Tomato Bisque | Fillet Steak | Parisian Potatoes | Asparagus Candied Parsnips | Sugar Plum Salad | Fruit Gelatin, Whipped Cream | |
| 25. Chowder | Fish | Browned Potatoes | Baked Banana Squash Turnips in Cream | Poinsettia Salad | Canned Whole Pear | |
| 26. Mulligatawny Soup | Meat Loaf With Mushroom Gravy | Browned Potatoes | Wax Beans Beets | Cottage Cheese and Ripe Olive Salad | Fresh Fruit Cup | |
| 27. Cream of Oyster Plant Soup | Sausage With Baked Grits and Syrup Oyster Stew | | Spinach | Sliced Tomato and Avocado Salad | Fresh Pear | |
| 28. Bouillon | Roast Beef | Baked Potato | Baked Zucchini Creamed Celery | Apple and Date Salad, Cheese Straws | Charlotte Russe | |
| 29. Vegetable Soup | Roast Lamb | Parsley Buttered Potatoes | Baked Eggplant Creamed Carrots | Apple and Date Salad, Golden Dressing | Apricot Icebox Cake, Whipped Cream | |
| 30. Consommé | Cube Steak | Browned Potato | Beets Summer Squash | Celery Hearts and Olives | Vanilla Cookies | |

*Recipes will be supplied on request by Anna E. Boller, The MODERN HOSPITAL, Chicago.

Is it true what they say about *FROZEN FOODS?*

WHAT'S all this talk about frozen foods today? . . . "What's good? What's right? What's wrong? What's the line of frozen foods for me?"

These are some of the questions food men are asking themselves—asking salesmen.

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That's important. Slow freezing of foods may take hours—days. It forms *large* ice crystals that pierce the cell walls of the food—breaks down the texture, allows flavor juices to seep out, freshness to disappear.

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All Birds Eye Foods come from the richest farm land in the country. Each crop is planted where Nature deals its kindest hand . . . peas in one part of the country, other vegetables in another. And planted by skilled farmers who know just when the crop is blessed with all the goodness Nature can bestow. Birds Eye Foods are picked, not hours young . . . not hours old . . . but just right. And frozen but a short time after by the quick-frosting equipment located right at the fields.

And we pick only the cream. All firsts—no seconds. And you'll agree that it's a rare packer indeed who can afford to reject seconds and thirds as Birds Eye does. Yet they cost you no more!

These are some of the things you should know when next contracting for your frozen foods. We have more facts to show how you can cut down your food losses—figure your portion costs accurately for months in advance—and bring to your menus a fresh variety they've never had before. Write Frosted Foods Sales Corp., 250 Park Ave., New York City.

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NEWS IN REVIEW . . .

Life Insurance and Pensions Provided for Employees at Strong Memorial Hospital

The employees of Strong Memorial Hospital, Rochester, N. Y., as well as of the University of Rochester of which the hospital is a part, were provided beginning on July 1 with group life insurance and retirement pensions.

In announcing the plan to the employees, Raymond L. Thompson, treasurer of the university, pointed out that the benefits of recent social security legislation passed by the federal government are not available to the employees of an educational institution.

The board of trustees of the university arranged for the insurance through the Metropolitan Life Insurance Company. In addition to providing life insurance and retirement pensions, those covered are entitled to use the visiting nurse service and the literature service of the company.

All full-time employees, except members of the academic staff, are eligible to join the plan as soon as they complete one year of continuous service. The university has had a teachers' annuity plan for senior faculty members for some years. Retirement takes place at sixty-five years of age but with the consent of the university may be earlier or later, earlier retirement involving a reduction in the scale of retirement payments.

If death occurs before retirement, the employee's beneficiaries will be paid not only his life insurance but also his total contributions for retirement income. On leaving the university employ before retirement, an employee may convert his life insurance without medical examination at the rate applicable to his attained

age. He may also either withdraw his total contributions to the pension fund or leave them with the company and draw a pension at his normal retirement age in proportion to the amount of his contributions. If he has contributed to the plan for ten or more years and chooses to leave his pension payments with the company his pension at retirement will include the amount purchased by the university's contributions as well as his own.

Payments are shared between the employee and the university in approximately equal amounts. Employees are divided into salary classes by \$400 intervals starting with \$1,000. The group earning less than \$1,000, will have \$800 of life insurance and a pension of \$1 a month for each year they contribute. For this the employee pays \$2.40 a month for the pension and \$0.48 a month for the life insurance. The higher salary classes pay more and receive larger benefits. The annual cost to the employee of insurance under this plan is \$7.20 per \$1,000.

Employees who do not subscribe to the pension and insurance plan are expected to sign a waiver which reads: "The university's retirement annuity and group life insurance plan has been thoroughly explained to me, and I fully understand it. I elect not to participate and recognize that by so doing neither any member of my family nor I will be entitled to any death or retirement payments from the university."

The announcement of this plan made late in June attracted widespread attention in the press.

New York City's Hospitals Show Diabetic Increase

An increase of over 100 per cent in the number of diabetic patients treated in the wards of the municipal hospitals of New York City from 1930 to 1935 was demonstrated by Dr. S. S. Goldwater, commissioner of hospitals, when he gave the figures for 1930 as 1,555 cases, and for 1935 as 3,491. A similar increase, he stated, had been reached by the out-patient clinics that are municipally owned.

Special diabetic clinics have been

established in nearly all of these hospitals, nine of them since 1930. No charge is made to indigent patients receiving insulin at the city's hospitals, and its use has increased from 20 to 50 per cent in 1935 as compared with 1933.

Some of these clinics have established appointment systems which ensure thorough, individual or group instruction.

New York City, according to Doctor Goldwater, is probably the largest single purchaser of insulin in the world.

Ask State's Hospital Facilities Be Expanded

Stressing the fact that Michigan's state hospitals are 3,500 beds short of caring for patients committed to them, the Association of Probate Judges at their annual convention asked that steps be taken to remedy present conditions. The state's institutions for feeble-minded, epileptics and mentally ill were characterized as a disgrace by the judges.

Genesee County is paying \$50,000 a year for the care of persons committed to the state hospital for whom there is no room. One probate judge cited the case of a feeble-minded girl who had been admitted to the Michigan Home and Training School, Lapeer, after a six-year wait. Many judges asked the hospital commission to double its demand upon the state, asking \$40,000,000 instead of \$20,000,000.

A four-year, \$5,000,000 building program was outlined by James T. Milliken, chairman of the state hospital commission's building committee, that would add 9,456 beds to the state's present accommodations of 12,956.

The augmented state administrative board, which has already earmarked \$500,000 for construction and is waiting for a reply on a petition asking \$450,000 from the Federal government, will be asked to appropriate an additional \$500,000 for construction on an addition to the Ypsilanti State Hospital, Ypsilanti, according to the governor. He said that he would recommend that the next legislature appropriate \$5,000,000 for the next fiscal biennium to finance a wider state building program.

British Vote to Accept Hospital Pay Patients

The British House of Commons on May 8 passed by a vote of 153 to 19 a bill to permit voluntary hospitals to accept paying patients provided they did not cut down on the provisions made for free patients.

Many voluntary hospitals in England have been prevented from accepting pay patients because of ancient provisions in deeds of gift or trust. The result is that poor patients have access to better hospital care than is available to middle or upper class patients. The latter must be cared for at home or in nursing homes, most of which are small and poorly equipped.

In the debate on the bill a few members objected to the principle of accepting pay patients because, in spite of the provisions of the bill, they feared less provision would be made for the indigent and class snobbery would be created. The bill received royal assent on May 21.

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National Biennial Nursing Convention Holds Nightingale Service in Hollywood Bowl

Approximately 10,000 nurses attended the memorial services to Florence Nightingale, held in the Hollywood Bowl on Sunday, June 21, to open the 1936 National Biennial Nursing Convention, which met in Los Angeles until June 26. A chorus of nurses in uniform opened the program with a group of songs, and Annie W. Goodrich, vice-president of the Florence Nightingale International Foundation, gave a short talk on the foundation. The program's finale was a brief appearance made by Kay Francis dressed in the costume she wears when portraying Florence Nightingale in "The White Angel."

At the joint opening session on Monday morning, tribute was paid to Clara Noyes, who for many years was national director of the American Red Cross Nursing Service. The greetings which Miss Noyes had prepared before her sudden death were read to the convention by Mary Roberts, a member of the National Committee on Red Cross Nursing Service.

The presentation of the Walter Burns Saunders Memorial Medal to M. Helena MacMillan, director of the school of nursing at Presbyterian Hospital, Chicago, for distinguished service in the field of nursing education, was the high spot on the evening program. Miss MacMillan, in 1897, organized the school of nursing at the Lakeside Hospital, Cleveland, now the Frances Payne Bolton school of nursing of Western Reserve University, one of the two schools in the country which demand college graduation as an entrance requirement. In 1903 she organized the school of nursing at Presbyterian Hospital, which now ranks as one of the best known in the country. For a number of years Miss MacMillan was editor of the nursing department of *The MODERN HOSPITAL*.

The National League of Nursing Education was concerned primarily with the accreditation of nursing schools. It voted to accept the responsibility for accrediting schools of nursing on a national basis; to appoint a standing committee to consult with the state leagues and state boards regarding the setting up and putting of the program into action; to authorize this committee to complete the plan for accrediting, and to put the plan into operation.

A national nurse placement service, to include vocational counseling, vocational guidance and placement, was suggested and approved by the house of delegates of the American Nurses' Association, with the purpose

of aiding nurses to secure positions for which they are most qualified. A committee with representation from the three national nursing organizations is to be appointed to consider the development of such a service.

The house of delegates also voted to ask the WPA to employ graduate nurses not on relief on WPA projects requiring nurses wherever the nurses on relief have been absorbed.

A resolution regarding staff nurses was passed unanimously by the American Nurses' Association to the effect that hospitals be urged to adopt the essentials of a good hospital nursing service as approved by the American Hospital Association and expressed in the "Manual of the Essentials of a Good Hospital Nursing Service." It was further resolved to urge the co-operation of the medical profession and community organizations in placing the care of seriously ill patients, in their homes, in the hands of professionally trained nurses, and that subsidiary workers be used only for such duties in the care of the sick as are outlined for these workers in the "Manual," and for similar duties in the home.

The joint boards of the American Nurses Association, the National League of Nursing Education and the National Organization for Public Health Nursing voted to hold the 1933 convention in Kansas City, Mo.

Susan C. Francis, superintendent, Children's Hospital, Philadelphia, was reelected president of the American Nurses' Association, and Amelia Grant, New York City, was reelected president of the National Organization for Public Health Nursing. Nellie X. Hawkinson, head of the department of nursing education of the University of Chicago, was elected president of the National League of Nursing Education.

8-Hour Day for City Hospitals

Employees in New York City's municipal hospitals have been granted their request for an eight-hour day by the board of aldermen. This change will add about \$1,000,000 to the annual budget of the department of hospitals, according to an estimate, but the board felt that the increased expense would be justified through better patient care. The bill, which may be suspended in times of emergency, does not affect administrative officials, medical and lay superintendents, physicians, interns, pathologists, roentgenologists, ambulance drivers or superintendents of nurses.

Significance of Out-Patient Clinics to Psychiatrists

As evidence of a tendency toward extra institutional treatment, Dr. Clarence O. Cheney, retiring president of the American Psychiatric Association, in his presidential address, quoted figures showing the growth of out-patient and child guidance clinics in New York State.

Twenty-five years ago, according to Doctor Cheney, there were no out-patient clinics in New York; psychiatry was almost exclusively an institutional career, and the membership of the American Psychiatric Association was made up entirely of superintendents of hospitals. In 1934, on the other hand, the state hospital system operated 70 out-patient clinics in which 6,802 patients were seen and the Department of Mental Hygiene maintained 162 clinics for child guidance and examined more than 4,500 children. Psychiatry, he pointed out, is becoming more and more an extra-institutional activity, and there has been an increasing number of association members who practice outside of institutions.

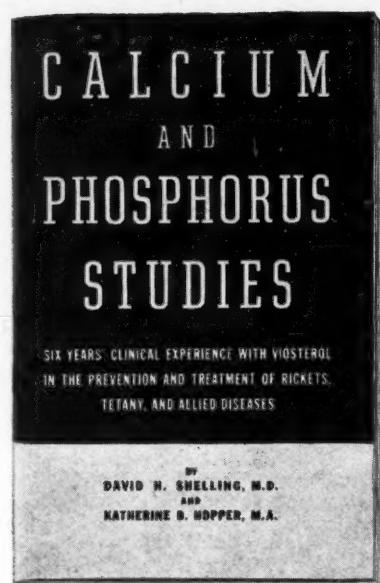
In discussing the increase of population in mental hospitals, Doctor Cheney emphasized that "an increased admission rate does not mean a corresponding increase in the actual incidence of mental disorders."

Hospital Service Under Contract

A yearly contract system, under which families are given hospital service for an annual fee of \$10 and individuals for \$5, has been inaugurated by Listowel Memorial Hospital, Listowel, Ont. During the first year of subscription, members are entitled to two weeks' hospitalization without charge, and those who renew will be permitted three weeks. The system has been in operation in British Columbia and Alberta for several years.

Hospital's Community Magazine

The Pilot, a magazine devoted to the interests of the Evanston Hospital Association, made its debut in June, sixteen pages of reading matter, $5\frac{1}{4} \times 7\frac{1}{4}$ inches in size. The cover picture presents three babies, one laughing, one thoughtful and one puzzled. The first article gives the history of the forty-five year old hospital. Others are human interest stories concerning a gift to the orthopedic department, the chef and the maternity department. The rest of the magazine is devoted to news notes and human interest chatter about the out-patient department which is symbolized by the picture of a door on the back cover of the publication.



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- Introduction
- Aim of study
- Criteria for the diagnosis of rickets
- Standardization of viosterol used
- Effect of viosterol in the treatment of the complications of rickets, and the value of effecting rapid healing of rickets.

PART II

- Effect of viosterol in infantile tetany
- Indications for and contraindications against the use of viosterol in diseases other than rickets and tetany
- The alleged toxicity of irradiated ergosterol
- Viosterol as compared with cod-liver oil in the prevention and treatment of rickets.

First of Three New York State Sanatoriums



Formal opening and dedication of the Homer Folks Tuberculosis Hospital, Oneonta, N. Y., took place on July 9. Hospital and health workers and county, city and village officials in Lewis, Madison, Chenango, Otsego, Delaware, Schoharie, Greene, Sullivan and Putnam counties, which comprise the district served by the new hospital, attended.

Governor Herbert H. Lehman, Homer Folks, Surgeon General Thomas Parran of the U.S.P.H.S., Dr. Augustus J. Hambrook of the Medical Society of the State of New York, and Dr. Robert E. Plunkett, general superintendent of tuberculosis hospitals in New York State, were among those

who spoke at the opening exercises.

The Homer Folks Hospital is the first of three state district tuberculosis hospitals to be completed, carrying out a provision by the legislature in 1931 to meet the needs of a group of rural counties too small to provide their own hospitals.

The legislature of 1936 passed by unanimous vote in each house a bill naming the Oneonta hospital after Homer Folks, for the past forty-three years secretary of the State Charities Aid Association and the aggressive sponsor of much of New York's public health, tuberculosis control and social welfare laws during the past generation.

Spends \$1,214,000 on Medical Supplies for Patients

The annual report of the Department of Hospitals for New York City shows that the total cost of medical and surgical supplies in 1935 for the department was approximately \$1,214,000. This was spread over nearly 10,000,000 units of treatment, a unit being one day's care in a hospital or a consultation at a dispensary. In these units there are sometimes single days of treatment representing from thirty to fifty dollars, as for example, a major surgical operation, supplemented by a transfusion and the employment of a special nurse. For the department as a whole the average cost of medical and surgical supplies for each unit is approximately \$0.136.

The per capita per diem cost for all patients and inmates was \$2.80. Extremes of cost are found in acute hospital services on one hand and custodial institutions on the other.

Free Care for Ford Riders

Anyone in North Brazil injured in an accident in a Ford car will receive free medical and surgical attention at the new hospital in Rio de Janeiro being built by the University of the Federal Capital. The university is seeking permission to name the hospital "Henry Ford," in recognition of the manufacturer's contribution toward development, economic improvement, sanitation and general welfare in the northern part of Brazil.

Close School of Nursing

Graduate Hospital of the University of Pennsylvania has held what may be its last nurses' commencement, though it hopes the abandonment of the training school will prove to be temporary. Lock Haven Hospital, Lock Haven, Pa., is closing its training school on September 1.

BEQUESTS AND GIFTS

CHICAGO, ILL.—Presbyterian Hospital and the Hospital Association of Lake Forest are each beneficiaries in the will of the late Cyrus H. McCormick of Chicago, Presbyterian Hospital to receive \$25,000 and the association, \$10,000.

ILLINOIS.—Three of the four charities to be made beneficiaries of over \$200,000 of the quarter-million-dollar estate of Jane Cairns, a retired Chicago school teacher, are the Home for Destitute Crippled Children, the Chicago Home for Incurables and the Shriners' Hospital for Crippled Children.

INDIANA.—The medical library of the late Dr. Bud Van Sweringen has been presented to Methodist Hospital, Fort Wayne.

ROCHESTER, N. Y.—The Rockefeller Foundation has made two grants to the University of Rochester school of medicine and dentistry totaling \$16,400. A \$10,000 grant will be used for investigation of filtrable viruses under the direction of Dr. George Parker Berry, professor of bacteriology, and the \$6,400 gift will be used by Dr. Stafford L. Warren, associate professor of medicine and radiology, in a study on the biologic effects of heat.

NEW YORK.—Two bequests of \$5,000 were received by the Buffalo General Hospital, Buffalo, from the estate of Mrs. Evelyn Howes Clark for the purpose of endowing two rooms, one in her name and one in the name of her late husband, Irwin Brayton Clark. Another bequest provides \$5,000 for the Arnot-Ogden Memorial Hospital, Elmira, N. Y., to endow a room in memory of her parents, Ephraim W. and Frances A. Howes. . . . The Rockefeller Foundation has appropriated \$10,000 to Columbia University with the provision that \$8,000 is to be used for research on poliomyelitis and \$2,000 for research on speech disturbances and neurologic problems.

PITTSBURGH, PA.—One-half of the bulk of the estate of the late Addison H. Gibson, amounting to two and a half million dollars, will be set aside to "procure medical aid for impoverished ill persons." A trust fund, to be known as the Addison H. Gibson Foundation is to be established. The will reads in part: "I desire and direct that the income . . . shall be used as my trustees shall see fit to procure medical aid or hospital facilities for poor and needy persons. It is my primary desire that such assistance be given directly to such persons, but I do not forbid such trustees from donating said income directly to such hospitals or other institutions furnishing such aid as they shall select and designate."



DEVASTATING FLOOD COULD NOT DEPRIVE THIS OPERATING ROOM OF LIGHT

The floods that overwhelmed the valleys of the East last spring disrupted electric service in many sections. But even in the worst stricken areas there were occasional buildings in which lights burned as normal. Many of these were hospitals, fortunately protected by Exide Keepalite Emergency Lighting Battery Systems. One Exide Engineer's Operating Report, made after a periodic inspection, says:

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NEW BUILDING PROJECTS

CANEY, KAN.—A two-story and basement addition is under construction at Caney Hospital, on the west side of the building, where the kitchen formerly stood. The basement will contain the kitchen, a dining room for employees, a laundry, furnace and gymnasium. The other two floors will be devoted to patients' rooms, with a section of the top floor given over to operating rooms. The old operating rooms will be made into additional patients' rooms. A garden is planned for the roof.

KANSAS CITY, Mo.—A surplus of fees collected will permit the addition of another story on the clinic building now under construction at the Bell Memorial Hospital. The 3-story clinic building was estimated at \$100,000, and the additional story will cost \$17,000. It will be used for classrooms according to Dr. H. R. Wahl, superintendent.

INGLESIDE, NEB.—A \$500,000 construction program is under way to relieve the desperately overcrowded conditions at Hastings State Hospital. Planned to accommodate 1,511 patients, this institution has been caring for 1,738. The \$500,000, part federal grant, part a state appropriation, will be used to erect a staff dormitory, a patients' building and for the installation of a sewage disposal system. The new program will provide accommodations for 2,500 patients. The dormitory will house approximately sixty day and seventy night staff members.

SOMERVILLE, N. J.—A pent house is under construction on the roof of the main building at Somerset Hospital, to provide quarters for the resident physicians, a solarium and a tile sun-deck for use of the patients. Two stories are also being added to that part of the building now used by the x-ray department. The first of these two will be given over to two wards, to be known as the Lindsley wards in memory of the late Clara Lindsley, a benefactor of the hospital; the second will contain delivery rooms and a nursery. Ten beds will be added to the maternity department of the hospital through the utilization of this space. Cost of the additions are to be \$43,185.

NEW YORK CITY.—Alterations amounting to \$450,000 are about to be made at Harlem Hospital that will result in a complete transformation of the older sections of the building. The work will be done entirely under the auspices of the WPA, a floor at a time, so the hospital's work will never cease. The new features will include an up-to-date emergency ward, a modernized x-ray department, a children's clinic,

a tuberculosis department and a laboratory. Recent additions to the hospital have eliminated the overcrowded condition previously present, and of the 665 available beds only 594 are occupied.

NEW YORK CITY.—Lenox Hill Hospital is to erect an addition, the gift of Dr. Max Einhorn, to be known as the Max and Flora Einhorn Memorial. The new structure will be of limestone, harmonizing architecturally with the present buildings. It will house an assembly room seating 370, two swimming pools, two public wards and a semi-private ward. York and Sawyer are the architects.

MUSKOGEE, OKLA.—Two new buildings are to be added to the Veterans Administration Facility at a cost of \$350,000. A two-story wing is to join the main hospital building with the old city hospital, and a three-story recreation hall is to be erected west of the main building. The ground floor of the two-story wing will be given over to the administrative division of the regional veterans bureau, while the second floor will contain laboratories, examination rooms, x-ray rooms, dental offices and clinical services. The space vacated in the old city hospital building by these departments will be utilized for patients. The recreation hall will contain an auditorium, a library, a barber shop, a canteen, a game room, a lunchroom and a kitchen.

GOOSE CREEK, TEX.—A two-story hospital is to be erected at a cost of \$50,000 by Drs. G. A. Lillie and Herbert H. Duke. It will contain offices for the two physicians, twenty-one patient rooms, and have a staff of twelve, including seven nurses. It will be ready for occupancy about November 1.

LONGVIEW, WASH.—A maternity wing, which will provide 20 additional ward and private beds for Cowlitz General Hospital, is now under construction. It will be a one-story unit, fireproof in construction, linked to the main unit with a glass enclosed arcade. A large nursery with a mirror view arrangement to permit mothers to observe their children from an adjoining room, a diet kitchen, a pathology laboratory, a doctors' reception room and a receiving ward are to be included in the addition.

BECKLEY, W. VA.—The Pinecrest Sanitarium is constructing a nurses' and physicians' home to accommodate forty nurses and two physicians with their families at a cost of \$82,000, provided from federal funds. New barns and other improvements scheduled for the institution are to cost an additional \$61,000.

Convalescent Home Built for Crippled Children

The convalescent home for crippled children, which is now under construction at Toledo, Ohio, is a concrete interpretation of a dream shared by members of the Toledo Society for Crippled Children, which dates its actual organization from 1920, but its first concerted movement from the year 1916.

The \$200,000 building is being erected on a nine-acre tract which the society purchased several years ago. It is to be one story high, save one wing, where a second story will provide nurses' quarters and linen rooms. The tank room will contain three tanks, and light and therapy rooms are planned so that the most advanced treatment may be given. Dormitories in one wing will provide accommodations for ninety children.

Four special vocational rooms, manual training quarters and four classrooms in which the board of education will conduct classes, are included in the plans and in the society's program. The nucleus of the building fund was derived from bequests made by the late William S. Walbridge, president of the society at the time of his death, and by Edward Drummond Libbey.

Hospital for Small Children

A 200-bed hospital for crippled children under six years of age is being constructed at a cost of \$325,000 at the Rome State School, Rome, N. Y. It will be used as an observation and collection center for these young children who will be dismissed, if possible, before they reach the age of six. If they continue to need hospitalization after passing their sixth birthdays, they will be transferred to other departments of the institution. All the children will be given preschool training, and the paralytics will receive special physical training, physiotherapy and heliotherapy. Children from two to six years will be in the wards on the first floor and those under two on the second.

Dedicate Two Buildings

Two new buildings were recently dedicated at Suffolk County Tuberculosis Hospital, Holtsville, N. Y. One, a hospital for children with accommodations for sixty patients, was named in honor of the late Dr. Joseph H. Marshall, first president of the board of managers of the hospital. The other, built for the care of acute cases and having fifty-four bed capacity was named for Dr. William H. Ross, Brentwood, first president of the county board of health.



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Midwest and Missouri Group Elect Officers

The Midwest Hospital Association, composed of hospital executives from Colorado, Kansas, Missouri and Oklahoma, held its tenth annual meeting in St. Louis on June 26 and 27, and elected William S. McNary, business manager of the University of Colorado school of medicine and hospitals, president, and Dr. J. H. Jennett, superintendent, Kansas City General Hospital, Kansas City, Mo., president-elect. Vice presidents selected were T. J. McGinty, superintendent, Southeast Missouri Hospital, Cape Girardeau, Mo., and H. E. Suderman, Bethel Deaconess Hospital, Newton, Kan. Florence King, Jewish Hospital, St. Louis, was reappointed executive secretary and treasurer.

Among those taking part in the association's program were Doctor Jennett, Frank J. Walter, administrator, St. Luke's Hospital, Denver; Ray F. McCarthy, executive director of the Group Hospital Service, Inc., St. Louis; Paul H. Fesler, superintendent, Wesley Memorial Hospital, Chicago; Mrs. Saidee N. Hausmann, superintendent, Levering Hospital, Hannibal, Mo.; John R. Smiley, superintendent, St. Luke's Hospital, Kansas City, Mo.; Joy Erwin, director of nurses, St. Luke's Hospital, Denver, and Dr. Malcolm T. MacEachern, American College of Surgeons.

At a separate business session, the Missouri Hospital Association elected L. C. Austin, superintendent, Menorah Hospital, Kansas City, president; Estelle Claiborne, superintendent, St. Louis Children's Hospital, St. Louis, vice-president; Florence King, executive secretary, and Laura A. Hornback, superintendent, Pike County Hospital, Louisiana, Mo., treasurer.

Manitoba Group Discusses Permanent Hospital Income

A paper read by George Stoker, secretary and business manager of the Winnipeg Municipal Hospitals, advocating that the present provincial wage tax be made a hospital tax when it has fulfilled its present needs, was one of the high points of the annual convention of the Manitoba Hospital Association at Portage La Prairie on June 29 and 30.

This suggestion by Mr. Stoker for a permanent and certain source of income to hospitals occasioned much discussion and the association decided to appoint a committee of five to consider the matter and report on its possibilities at the next meeting.

The suggested accounting forms, now recommended for use by all Canadian hospitals, were reviewed by G. D. Illiffe, comptroller general's de-

partment, who recommended a survey of the statistical methods of Manitoba hospitals with a view to the adoption of these forms. The association decided to postpone the adoption of the forms until they have been further recommended by the Canadian Hospital Association.

Dr. G. S. Williams, superintendent of Children's Hospital of Winnipeg, was elected president of the association; Honor Y. Tregear, superintendent, Carman General Hospital, Carman, was elected vice president; Dr.

A.H.A. Sept. 28-Oct. 2 Cleveland

Thirty-Eighth Annual Meeting

A.H.A.

O. C. Trainor, Misericordia Hospital, Winnipeg, was elected secretary, and W. R. Bell, Souris, treasurer. J. H. Metcalfe, Portage La Prairie, retiring president, has been made honorary vice president.

Two New York Hospitals Benefit

Mount Sinai Hospital and Montefiore Hospital, both of New York City, have received bequests of \$50,000 and \$25,000 respectively in the will of Mrs. Stella H. Abrahamson. The bequest to Mount Sinai directs that the income be used annually "for an award in each year to such former intern or physician resident in Mount Sinai Hospital, or to such other physician, who, in the opinion of the fellowship committee, is most deserving of the same, to be used by the recipient under the direction of the proper officials of said hospital for research work and study in the field of neurology and psychiatry." The fund designated for Montefiore Hospital will be used for the same purpose, according to the terms of Mrs. Abrahamson's will.

Perth Amboy Seeks Funds

Efforts are being made to establish a fund of \$300,000 for improvements to be made in the Perth Amboy General Hospital, Perth Amboy, N. J. The hospital and the city commission have filed application with the Works Progress Administration for \$240,000, the balance to be made up by the city. This sum is necessary to answer the urgent need for the addition of new wings and other facilities.

New York Hospital Reports Increasing Free Care

Free care and below cost care of the needy totaled an expenditure of \$856,726.09, according to the 164th annual report of the New York Hospital. This figure represents an increase of \$91,429.09 over the previous year. Patients treated totaled 80,163, an increase of 16,062 over the year preceding.

Days of bed care totaled 264,398, an increase of 19,486. Seventeen new beds were opened, bringing the hospital's capacity to 879 beds and 131 bassinets.

Cost of operation was \$2,491,860.33, an increase of \$101,162.46, or 4.25 per cent. The operating income, not including revenue from investments, was \$1,473,016.06 as against \$1,337,878.34 in 1934, an increase of 10 per cent. The deficit was reduced by \$33,975.26.

White Plains to Rebuild

Following a survey of hospitalization needs of Westchester County the board of governors of White Plains Hospital, White Plains, N. Y., has decided to erect a 200-bed unit at an estimated cost of \$850,000. The new building will replace the main structure which was erected thirty years ago and is no longer adequate for the needs of the community. This will make possible several additional services, including the care of private chronic cases, for which the survey showed an acute shortage of hospital accommodations, not only in Westchester, but in the metropolitan area.

Biological Photographers Meet

The Biological Photographic Association is holding its sixth annual convention in Boston, September 24 to 26. Among the papers to be given are one on experimental motion pictures of the larynx by Leonard Julin, Mayo Clinic, Rochester, and a paper on optics by Prof. A. C. Hardy, Massachusetts Institute of Technology.

Coming Meetings

Institute for Hospital Administrators.
Next meeting, Chicago, Sept. 9-23.

American College of Hospital Administrators.
Next meeting, Cleveland, Sept. 26-28.

American Protestant Hospital Association.
Next meeting, Cleveland, Sept. 26-28.

American Hospital Association.
Next meeting, Cleveland, Sept. 28-Oct. 2.

National Association of Nurse Anesthetists.
Next meeting, Cleveland, Sept. 29-Oct. 1.

Children's Hospital Association.
Next meeting, Cleveland, Sept. 30-Oct. 1.

American Dietetic Association.
Next meeting, Boston, Oct. 11-16.

American College of Surgeons.
Next meeting, Philadelphia, Oct. 19-23.

Ontario Hospital Association.
Next meeting, Toronto, Oct. 19-23.

American Public Health Association.
Next meeting, New Orleans, Oct. 20-23.



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 - 2** Usual solution used
 - 3** Average initial dosage in c. c.
 - 4** Average rate of injection in c. c. per hour
 - 5** Average total dosage per day in c. c.
 - 6** Indications for discontinuance

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NAMES IN THE NEWS...

DR. PAUL M. FULMER, superintendent of Pulaski County Hospital, Little Rock, Ark., has resigned from that position to accept one on the staff of the Veterans' Administration Facility, Milwaukee, Wis. He will be succeeded at Pulaski by DR. JOHN R. MAY, assistant superintendent of the institution.

JOHN C. DINSMORE, former superintendent, University of Chicago Clinics, sailed for London on July 15. He has been appointed managing director of Searsint, Ltd., London, England, for reorganization purposes. This is the English branch of Sears Roebuck and Co.

DR. EMMET B. BAY has been named associate dean of the division of the biological sciences of the University of Chicago, in charge of Rush Medical College.

DR. BLACKBURN G. TUCKER, superintendent of the Davidson County Tuberculosis Hospital, Nashville, Tenn., died at the age of sixty, when he contracted pneumonia while in a hospital for observation. Under Doctor Tucker's guidance, the tuberculosis hospital has grown from a nine-bed institution in 1917 to a 300-bed hospital with a waiting list at all times. This expansion was all accomplished without the issuance of bonds or the incurrence of any debt; the institution is entirely debt-free.

NATALE COLOSI, M.A., Ph.D., has been appointed general director of Parkway Hospital, 123 West One Hundred Tenth Street, New York City. Doctor Colosi has been associated with the New York University College of Medicine as instructor in bacteriology.

DR. BERNARD L. WYATT, formerly director of the Desert Sanatorium and Institute of Research, Tucson, Ariz., has received the James E. Stacey Award for 1936, awarded by the University of Cincinnati college of medicine. The award, which consists of \$100 and a medal, is given for significant contribution in the field of focal infection.

DR. WILLIAMS MCKIM MARRIOTT, dean of Washington University school of medicine, St. Louis, since 1923, has resigned to become dean of the University of California Medical School, San Francisco.

DR. ARNOLD A. KARAN, formerly acting superintendent of the Rhode Island State Sanatorium at Wallum Lake, R. I., has been appointed assistant director of the Jewish Hospital of Brooklyn.

DR. ROBERT Y. GRONE, assistant to the chief surgeon at the George F. Geisinger Memorial Hospital, Danville, Pa., has been made director of the Shamokin State Hospital, Shamokin, Pa., to succeed DR. GEORGE W. REESE.

NORMAN R. MARTIN, superintendent of Los Angeles County General Hospital, Los Angeles, for five years, has announced his resignation to be effective August 15. He has been ill for some time. EVERETT GRAY, former superintendent of Olive View Sanatorium, Olive View, Calif., has been appointed his successor.

HELGA SANDER, Jamestown Hospital, Jamestown, N. D., has been appointed superintendent of Huizenga Memorial Hospital, Zeeland, Mich.

ROBERT W. GLOMAN, assistant superintendent, Nanticoke State Hospital, Nanticoke, Pa., is the new superintendent of Wyoming Valley Homeopathic Hospital, Wilkes-Barre, Pa., succeeding MARIAN A. BATDORF who has accepted a two-year contract as superintendent of Matanuska Valley Hospital, Palmer, Alaska.

DR. JESSE E. BRUMFIELD has been appointed head of the Colony for Feeble-Minded, Ellisville, Miss., to succeed DR. ROMEO HALFACRE.

DR. JOSEPH TURNER, director of the Mount Sinai Hospital, New York City, has been appointed administrative consultant of the Neustadter Foundation, a heavily endowed institution maintaining the Neustadter Home for Convalescent in Yonkers, N. Y.

WILLIAM M. BREITINGER, superintendent of Reading Hospital, Reading, Pa., since 1923, died on June 24. He had been ill for several months and had planned his retirement for July 1.

LAURA B. WILSON, superintendent, Children's Hospital, Pittsburgh, addressed the Third World Conference of Workers for the Crippled, at Budapest, Hungary, on "Proper Convalescent Care."

CHARLES F. NEERGAARD, hospital consultant, has been appointed by the New York Supreme Court to represent the certificate holders of the \$600,000 mortgage bond issue on the Bronx Hospital, New York City.

CHARLOTTE W. AGER has been appointed superintendent of Columbia Hospital, Columbia, Pa., to succeed MRS. MINNIE SAVIN who resigned. Miss Ager, who for five years was in charge of the Bryn Mawr College Infirmary, for the past seven years has been affiliated with the Homeopathic

Medical and Surgical Hospital, Reading, Pa. Mrs. Savin has accepted a post in industrial work for a large oil company of Philadelphia.

DR. ROBERT R. HAYS is now assistant superintendent of Blair County Hospital for Mental Diseases, Hollidaysburg, Pa.

MILLIE JACOBSON has been appointed to succeed MRS. ELIZABETH WOOLSON as superintendent of St. Luke's Hospital, Milwaukee, Wis.

DR. SETH F. H. HOWES, who in April was appointed superintendent of the Rhode Island State Infirmary, Howard, R. I., has been appointed superintendent of the State Hospital for Mental Diseases at Howard to succeed DR. ARTHUR NOYES. Dr. DEMETRA ITSINA, senior resident physician at the infirmary, will become acting superintendent there.

DR. MARTIN I. MARSHAK, former superintendent of the Jewish Consumptive Relief Society Hospital, Denver, died in Bayonne, N. J., at the age of fifty years. Doctor Marshak was a specialist in heart and lung diseases and was at one time assistant superintendent of the Cook County Hospital, Chicago.

DR. VIRGIL H. DANFORD, superintendent of Rhode Island State Sanatorium, Wallum Lake, R. I., died recently.

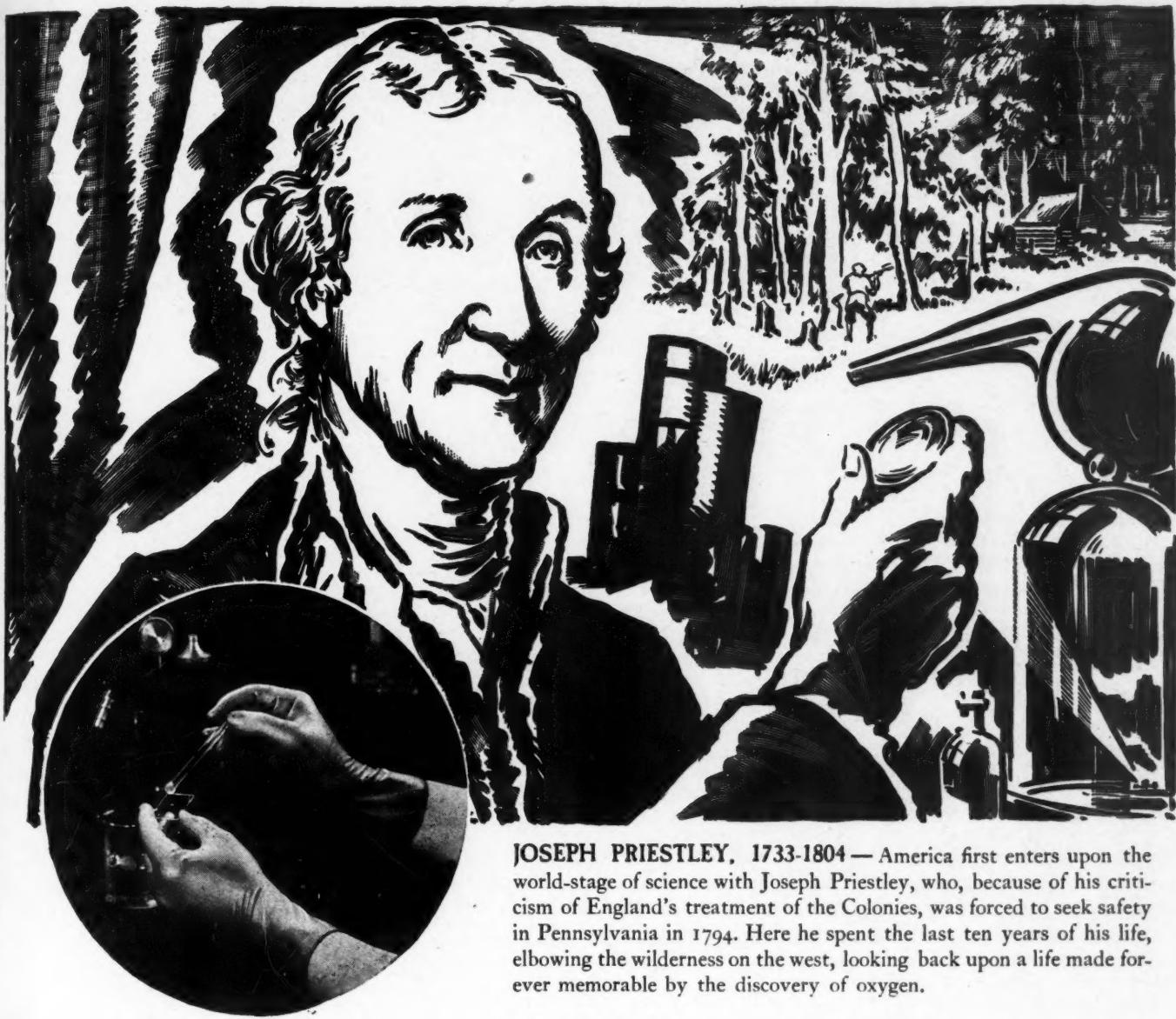
Memorial Honors X-Ray Heroes

Among the 165 heroes of science who lost their lives in medical research and were honored during April by the erection of a sandstone memorial bearing their names are forty American radiologists and roentgenologists. The memorial stands in front of the Roentgen Institute, St. George's Hospital, Hamburg, Germany. R. M. Machlett and E. W. Caldwell, New York; W. I. Dodd, Philadelphia; F. H. Baetjer, Baltimore; W. C. Engelhoff and R. Friedlander, Chicago, and E. Fleischmann, San Francisco, are among those honored. The list includes forty-six French and seventeen German scientists.

Act to Beatify Mother Cabrini

Mother Frances Xavier Cabrini, who in 1892 established the Columbus Hospital in New York City and later, in 1905, built a second Columbus Hospital in Chicago, is now being considered at Vatican City as a subject for beatification. Mother Cabrini, founder of the institute of missionary Sisters of the Sacred Heart of Jesus, came to the United States from Italy to work among Italian immigrants. She was born near Lodi, Italy, the daughter of Lombardi nobility. Mother Cabrini Hospital, Chicago, was founded as a result of her inspiration.

PIONEERS IN MEDICINE AND SURGERY . . . No. 15



JOSEPH PRIESTLEY, 1733-1804 — America first enters upon the world-stage of science with Joseph Priestley, who, because of his criticism of England's treatment of the Colonies, was forced to seek safety in Pennsylvania in 1794. Here he spent the last ten years of his life, elbowing the wilderness on the west, looking back upon a life made forever memorable by the discovery of oxygen.

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LITERATURE in ABSTRACT • •

Conducted by E. M. Bluestone, M.D.

Caring for the Cancer Patient

In view of the fact that 153,000 people in the United States died of cancer in the year 1935 and approximately 450,000 who have cancer are now living in the United States, the author* considers the treatment of cancer to be a major problem in medicine today.

The campaign of the American Society for the Control of Cancer has attempted to disseminate to the public facts, which will lead them to present themselves to the medical profession early in the course of their disease. Once the patient has placed himself in the hands of the physician, it is the responsibility of the medical profession to see to it that he is treated in a well equipped and organized hospital and by a capable medical staff.

The duty of the hospital management to the cancer patient is to provide the medical staff with the necessary equipment and quarters to conduct both clinical and research work. There are three types of clinics or hospitals for the care of cancer patients, (1) the special cancer hospital, (2) the cancer clinic and (3) the diagnostic cancer clinic.

The special cancer hospital must be heavily endowed. It should be equipped with a large amount of radium and x-ray machines of all voltages. It should have a department of physics to be responsible for the various types of radium applicators and the measurement of output from the x-ray therapy machines. A laboratory for biophysical research should be incorporated. With the introduction of the relation of hormones to tumors it is now important that there be a department of oncologic physiology. A department of biology is of prime importance for the study of cancer incidence and development and for breeding experiments. A chemical laboratory is a necessity.

The pathological laboratory is the basis on which all good cancer diagnosis rests. The pathologist must be one with vast experience who can grade tumors in the scale of malignancy. He must cooperate with the clinical services of the hospital and group discussions between the pathology department and the clinicians will undoubtedly redound to the good of the patient. In a special cancer hospital with a large amount of material the services may be divided so that specialists may be developed in a particular field of cancer. The clinical services

should all be surgical, for cancer is primarily a problem for the surgeon alone or in combination with the radiotherapist.

The cancer clinic in a general hospital is of importance for the consideration, diagnosis and treatment of all patients with malignant disease. The Greenough-Crowell plan provides for the organization of a small group, who are interested in cancer, from the already existing professional staff. This group meets once or twice a week, sees all the cases and determines the problems as presented by each particular patient. A general hospital must have a minimum standard of requirements for the treatment of malignant diseases. This should include at least low and high voltage x-ray machines and 200 mgs. of radium.

The diagnostic cancer clinic comprises a group of men interested in cancer who meet at intervals to consider the diagnosis and treatment of cancer patients in their locality. Lacking therapeutic facilities this group refers the patient to a hospital where the required treatment can be obtained.

*Adair, Frank E.: What the Medical Staff and Hospital Management Can Do for the Cancer Patient, Bull. Am. Coll. Surg. 21:104, 1936. Abstracted by Arthur H. Aufses, M.D.

Radiology—a Specialty

This bulletin emphasizes the fact that radiology is a specialized branch of medicine* and that the practice of radiology is the practice of medicine.

It objects to the plan of hospitals charging a flat fee for diagnosis when that procedure includes all necessary roentgenologic examinations. The hospital has no right to enter the corporate practice of medicine with the physician as an employee, according to this publication.

Objection is also raised to the suggestion of dividing the practice of radiology into a professional and technical service. It is claimed such division cannot be effected without detriment to the quality of service rendered to the patient.

Many states have laws against the corporate practice of medicine. Such laws are violated where improper hospital-radiologist relationships exist. Ways are being sought to obtain the help of organized medicine in the abolition of these "abuses."

Many hospitals have abandoned the "unjust" arrangement whereby the radiologic department is required to

make some profit for the hospital. Group hospitalization by which a nonprofit corporation guarantees a certain number of free hospitalization days is sound and ethical only as long as it excludes every type of medical care. Diagnostic radiologic examinations, therefore, should not be included.

*Chamberlain, W. E.: The Provision of Radiology in the Practice of Medicine. Am. Col. Radiology, Bull. 2, p. 16, 1936. Abstracted by A. J. Bendick, M.D.

Utilizing Synthetic Atmospheres

Synthetic atmospheres which challenge the superiority of ordinary atmosphere for maintaining animal life can be created by mixtures of oxygen, helium, argon, according to Dr. J. Willard Hershey, McPherson College, McPherson, Kan.*

Helium and oxygen apparently seem to be the best. Normal life will exist normally and apparently better in a mixture of 79 per cent helium and 21 per cent oxygen than in normal atmosphere. Animal life will be supported normally in a mixture of 75 per cent argon to 25 per cent oxygen.

Pure gases are invariably fatal. Animals died in pure oxygen in two to six days; in pure hydrogen, two to thirty-six minutes; pure nitrogen, six minutes; pure argon, three minutes; in neon, one minute, forty seconds; helium, two minutes and forty seconds; in nitrous oxide, ten minutes, and in carbon dioxide in fifty-five seconds.

There is a wide range of values and uses of synthetic atmospheres, for instance, in deep sea diving, mines and submarines where foul air is encountered. Even aviators may carry a supply when they are to fly in the stratosphere.

The use of the oxygen tent is a well established practice today. Medical men little understand the other gases, especially rare ones. There is probably a field for the clinical application of synthetic atmospheres.

*Synthetic Atmospheres Studied. Heat. and Ventil. June, 1936, page 32. Abstracted by J. R. Clemons, M.D.

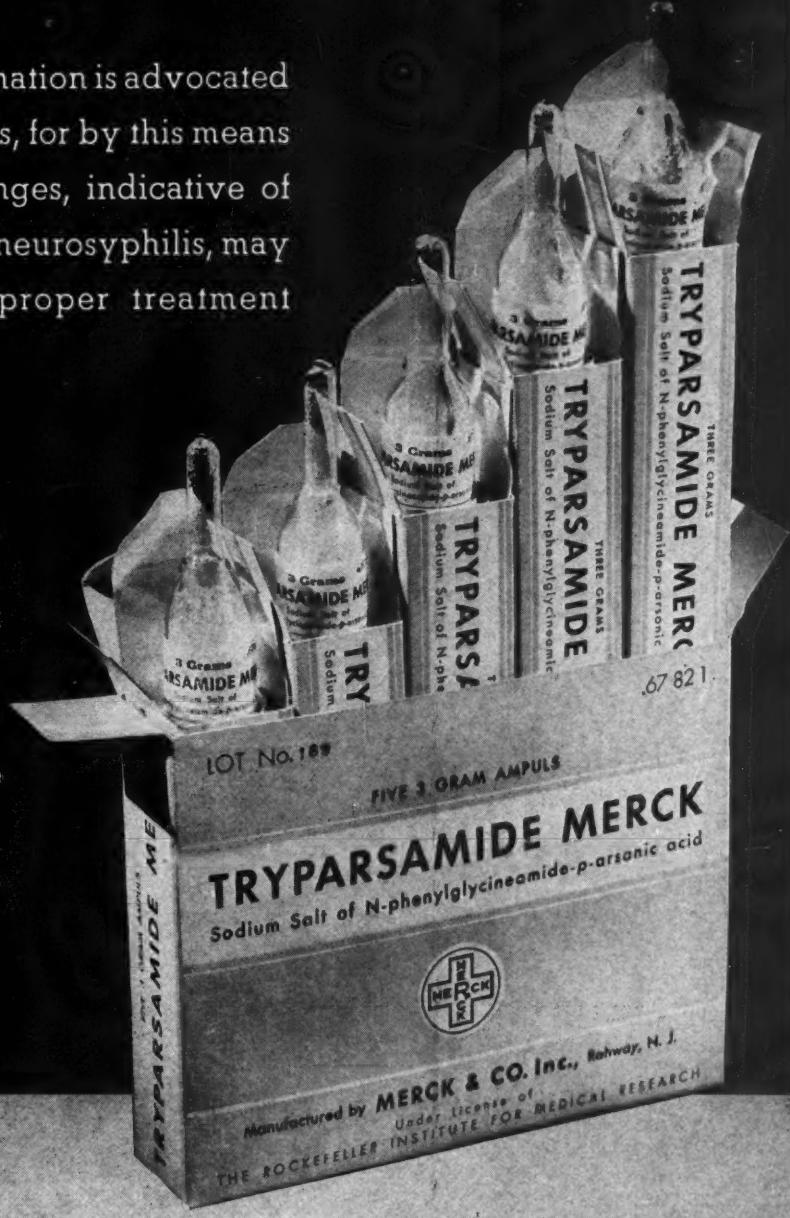
Principles of Good Buying

Buying is the beginning of all business, while profit is the result of business ability.* Thoughtful buying, careful training of labor and the capitalization of oneself in methods of operation are important factors, if profits in the restaurant business are to be made. The largest profits are usually earned by men possessing the greatest initiative and ability. The greatest percentage of a restaurant operator's costs are represented by food products alone. Therefore, success or failure may be

NEUROSYPHILIS

A spinal fluid examination is advocated in all cases of syphilis, for by this means early serologic changes, indicative of a pre-disposition to neurosyphilis, may be detected, and proper treatment instituted.

The use of Tryparsamide Merck is an office procedure. It is administered intravenously, does not disrupt the patient's daily routine of life, and is inexpensive.



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determined by the ability and methods used in purchasing foodstuffs.

It is important that those persons purchasing food know the desires of the patrons, and also be familiar with the essentials or the requirements necessary to the production of satisfactory food. The fundamental principles of good buying are intuition, experience and logical reasoning, which are acquired only through study and thought.

It is unwise for a buyer constantly to change merchandise for a matter of saving a few cents, especially in staple items which are used in the preparation of many foods. A constant change in materials used prevents standardization of food quality. All new food products should be subjected to tests before an attempt is made to change the merchandise. The guests should be the ultimate judges.

It is advisable to inspect products before purchasing, and if at all possible all purchases should be inspected when delivered.

Know your cost per unit or serving and stay under that price. No fast rule can be set for the size or weight of various raw food products to be used. The question is, which is best suited to the needs and at the same time most profitable.

The menu should be planned in advance as it is advantageous to profitable buying. The menu and market list must work together, and both must be flexible and subject to change as conditions warrant. Those responsible for the quality of the food and the operation of the restaurant should be given the opportunity to rearrange the menu so as to serve the best food at the lowest price.

*Kuennen, Ralph H.: Buying for Profit in the Progressive Restaurant, Am. Rest. Mag., June, 1936. Abstracted by Ernestine Dunmire.

Poison on Fruit

The spray residue situation has been a problem with the Department of Agriculture for the last twenty years.* Residues of arsenate of lead left on food carry toxic substances which are seldom large enough to cause acute poisoning, but which over a period of time may lead to a definite impairment of health due to cumulative effect. The symptoms that follow a prolonged intake of lead or lead compounds include anemia and pallor, lead line of the gums, intestinal colic and injuries to the nervous system, kidneys and liver. Chronic arsenic poisoning resembles that of lead with its gastro-intestinal catarrh, liver damage, impaired nutrition and neuritis.

The bureau of chemistry has made intensive surveys of the fruit producing areas; their research laboratories have perfected an acid solution for washing the fruit as well as an im-

proved method for determining the lead content of food in a shortened period of time. An export certificate plan was devised for large producing Western states whereby every export shipment contains a certificate of analysis showing that the fruit complies with the established tolerance. This tolerance has been fixed at 0.01 grain per pound of solid food for arsenic, at 0.018 grain per pound for lead, and at 0.01 grain per pound for fluorine.

Several states, among them Colorado, Michigan and Montana, have taken steps in the direction of controlling the situation within the state, since Federal control is possible only in interstate commerce.

At the present time, research is going forward with the hope of discovering a substitute for arsenate of lead which will be equally effective against insect pests and less poisonous to man.

*Geiger, Becker and Crowley: Poisonous Substances in Food, Am. J. Pub. Health, 26: 382 (Apr.) 1936. Abstracted by Ann Bass.

Air Conditioned Operating Rooms

One of the finest examples of the well designed hospital* is the Robinson Memorial, the largest unit of Massachusetts Memorial Hospitals, Boston.

There are six operating rooms—one orthopedic, one obstetric, and four regular. Each regular operating room has a viewing gallery on the floor above. The galleries have heavy plate glass windows set at an angle slightly above the horizontal enabling spectators to look down on to the table. The operating surgeon explains the various steps through a suspended microphone, his voice being carried by amplifier to the gallery. Observers' questions are dropped through a chute to the operating room where they are read to the chief surgeon who replies by microphone.

All electric fixtures in the operating room are protected to prevent entrance of sparks, and the humidity is maintained at about 55 per cent to minimize danger of explosion. All windows are set with double glass to prevent condensation of moisture during cold weather. In case of failure of the hospital's own power line, generated by an oil fired plant, switch is automatically made to the public electric lines.

All floors and operating rooms have thermostatically controlled solution cabinets maintained at 99° to 100° F.

During the winter, air entering the operating rooms is heated, humidified and cleaned. Finally it is passed through two heating coils entering the main distributing duct at about 130°.

A thermostat in each operating room operates mixing dampers regu-

lating the amount of warm air entering. No radiators are used. The heat is supplied by the air. An exhaust fan constantly takes out at floor level as much air as enters at the ceiling, giving approximately eight changes each hour. No grilles are used; the ducts are kept open to prevent dust collection and to facilitate cleaning.

The viewing galleries are heated and ventilated by grilles placed at the end of the rooms, cool air being admitted by mixing dampers.

In the scrubbing-up rooms the surgeons touch nothing that would transmit infection. A glass partition enables them to see into the operating room.

The preparation rooms have constant temperature chambers for solutions and the warming of blankets. Only the workers touch the dressings before use, for prepared dressings are pushed into a wall container which opens into the operating room.

In certain workrooms a special direct-indirect heating and ventilating system is used. Glass wool filters clean the outdoor air.

In the room for premature babies the temperature can be brought up to 95°. It is controlled by a thermostat. The method here is simple, warm air passing over a pan of water placed on a concealed radiator.

All rooms except operating rooms, offices, and viewing galleries have concealed radiators of copper fin type with flush grilles.

Special features of the steam sterilizing equipment are colored dial and twenty-four-hour recording thermometers.

The building, heated by steam at one pound pressure from a central heating plant on another street, has three thermostats which modulate the supply of steam to maintain temperatures at 72° to 73° F.

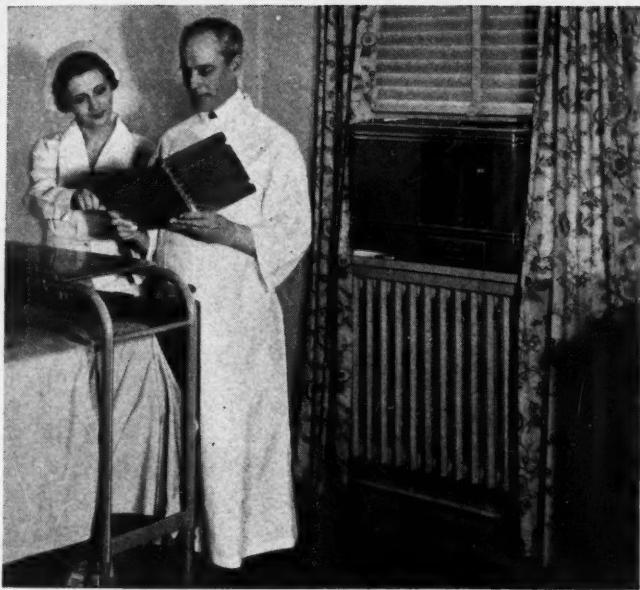
*Modern Hospital Uses Winter Air Conditioning in Operating Rooms, Heat. & Ventil. 33: 32 (May) 1936. Abstracted by Louise Large.

An Executive Housekeeper's Code

The third annual congress of the National Executive Housekeepers Association was held in Chicago at Hotel Stevens in May. At that time a "Code of Ethics" was adopted.* There are three major divisions—the profession, business dealings and relations with employees.

In brief, the code requires that the executive housekeeper in her profession be responsible for the well-being of her patrons and guests; uphold the standards of her institution and strive to operate her department in a fair, economical manner; keep personal prejudices entirely removed from her professional contacts, and exchange in-

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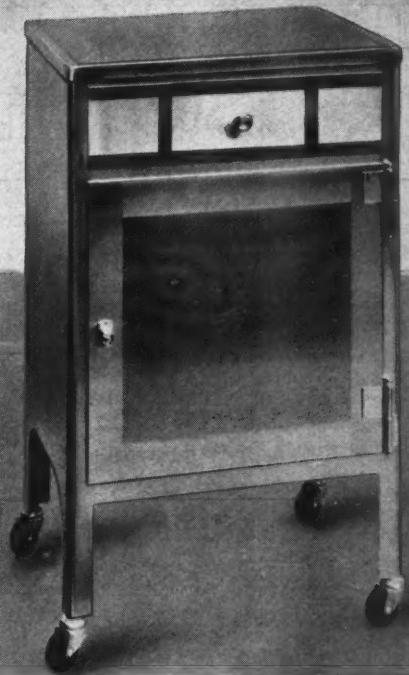
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formation and experience with her fellow members.

In her business dealings, the executive housekeeper should not solicit patrons from other houses; should not solicit a commission in return for influence exercised; should abide by terms of her contract with her employer, and strive to secure advancement in salary solely through merit rather than personal influence.

In her dealings with employees, the executive housekeeper should assume responsibility for training potential executives in order to raise the standards of the profession; take responsibility for the health and happiness of her workers, and strive to hold the respect of her employees through efficiency, impartiality, kindness and a professional attitude.

A good executive housekeeper will seek to keep herself informed regarding all matters pertaining to the intelligent and effective operation of her department; is willing to share her knowledge for the benefit of others; meets criticism with open-mindedness and courtesy, and conforms to a standard of personal conduct which will bring honor to her profession.

*Executive Housekeepers Adopt Code of Ethics, Hotel Month., June, 1936. Abstracted by Jane Murphy.

Air Conditioning Problems

Short circuits in electric conduits occasionally occur after installation of air conditioning due to the collection of water in the conduits.* In connection with this problem various manufacturers have made several suggestions beyond that of merely local conditions.

One suggests that unless the conduits are sealed at the ends there may be air flow through them. If the conduits terminate where the air is humid the water vapor will diffuse through the conduit. Then if the outside surface of the conduit is closed due to being near the cold air ducts, the water vapor would be condensed. Even if the conduits are reasonably well plugged there is some possibility of "breathing."

A second possibility is that the conduits may in some places become very cold due to proximity with the cold air supply ducts. If they pass through any warm humid place not air conditioned, condensation would be caused on the outside of the conduit and might leak through the joints.

As a solution to the condensation due to change in temperature, one manufacturer suggests either conduit runs should be laid so that conduits will drain, or an airtight fitting recently introduced on the market should be used.

A third man states that in new construction electric conduits should be

separated from cold air ducts or refrigeration piping. If they must cross, insulation should be used between them. Where installation is already made the difficulty could probably be corrected by preventing air circulation through the conduits. This is particularly true of long vertical runs open at each end which would draw in warm humid air at the top and discharge cold dehumidified air at the bottom leaving the moisture inside the conduit.

Building managers should carefully consider this problem and discuss it with air conditioning and electrical engineers to avoid such difficulty.

*McLaughlin, W. J.: Air Conditioning and Short Circuits, Skyscraper Management, April, 1936. Abstracted by J. R. Clemons, M.D.

Juice Yield From Oranges

The results of a study* begun in the fall of 1934 by the Greater New York Dietetic Association on the yield of juice from different kinds and sizes of oranges showed that: small oranges yield more juice; there is no difference in the yield of juice from California or Florida oranges when they are in season; California oranges yield the most juice during the month of October, while Florida oranges give the greatest yield in March; the average maximum yield to be expected from one case of oranges is 23 quarts of juice, and the average minimum yield, 14 quarts of juice; the machine method is preferable to the hand method for the extraction of the fruit juice.

In a similar study made at Montefiore Hospital, New York City, in the winter of 1935 and spring of 1936 it was found that the larger size Florida oranges gave a better yield of juice, and that No. 176 oranges were preferable to No. 250 oranges for the extraction of juice. It seems evident that there is a yearly variance in crops and that it is advisable to make a short study each season.

*Purchasing Oranges, Tr. Nurse & Hosp. Rev., p. 257 (Mar.) 1936. Abstracted by Hazel C. Swim.

Paper vs. Celluloid Films

An accurate diagnosis of pulmonary tuberculosis is dependent on x-ray studies. This is particularly true of early cases where abnormal physical signs may be minimal or absent. Several extensive surveys of school children in health studies are to some degree hampered by the cost of roentgen films. The substitution of the fluoroscope for this purpose is unsatisfactory because of the lack of fine detail, absence of a permanent record and the fact that the opinion of only one observer usually is available.

At the request of the National Tu-

berculosis Association, a comparative study* of the use of paper and celluloid films was carried out in 1,000 cases. The paper film is a fairly tough and stiff white paper base, coated on one side with a sensitized emulsion. It is practically noninflammable. The technique of exposure is much the same as with celluloid films, and a special developer supplied by the manufacturers is required.

The film is best viewed by direct illumination with bright daylight or with a 100-watt lamp behind "daylight" glass. The authors conclude that the celluloid film is appreciably superior for showing shadows of fine detail. However, the paper film is a satisfactory substitute and the cost is approximately one-half of the celluloid film. It would seem that this great reduction in expense will facilitate the present plan of examining large groups of school children in an effort to "screen out" early cases of pulmonary tuberculosis.

*Barnard, Margaret Witter; Amberson, Jr., J. Burns, and Loew, Marion Franklin: The Technique of Using Paper Films for Roentgenograms of the Chest, Am. Rev. Tuberc. 25:6 (June) 1932. Abstracted by J. Masur, M.D.

Heat Generated by Lighting System

In illuminating interiors the trend is toward higher wattage capacities, which generate a correspondingly larger amount of heat. More consideration must therefore be given in the future to the heat generated by the lighting system.*

About 90 per cent of the energy from a clear bulb, gas filled lamp, is in the form of heat, and between 50 and 90 per cent of this affects the cooling system. With 16 to 20 watts of light per square foot for a seven-hour period, in a room that has doors and windows closed and a regular cooling system, the temperature rise would be from 14° to 16°.

The best solution is extra cooling capacity when the amount of radiant heat is only 50 per cent. But at 16 to 20 watts per square foot, heat absorbent glass should be utilized under or covering the light unit, as this enables twice as much heat to be removed by the ventilating air as is possible from the usual types of suspended lighting. In winter this heat could be used for an upper floor, and in summer forced outdoors. A false ceiling, open to the top light units, with an air intake on one side and an exhaust fan on the other side of the false ceiling and water cooled lamps are also points that are worthy of consideration.

*Abstract of address by Walter Sturrock: Heat Gain from Artificial Light, Heat. & Ventil. 33:30 (May) 1936. Abstracted by Louise Large.



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BOOKS ON REVIEW

HOSPITAL ACCOUNTS AND FINANCIAL ADMINISTRATION. By Capt. J. E. Stone. London: Faber & Faber, Ltd. Second edition. Pp. xvi, 278, 21 shillings. This volume is a second edition of a book originally published in 1924. It contains a complete discussion of the financial accounts of hospitals, of the needs and methods for calculating departmental costs and considerable discussion of statistics and financial control.

Captain Stone has included in this volume not only material dealing with the theory of accounting and a proposed uniform classification of financial records. He has also included a considerable general discussion of hospital business problems, such as the handling of the accrual system of accounting (income and expenditure system), depreciation and renewals, budgeting, the control of stores and taxation.

An important aspect of this volume is Captain Stone's reiteration that hospital accounting should be centered around the organization units of the hospital (such as administration, laundry, dietary, special departments) and not on the basis of the objects of expenditure, such as salaries, supplies.

In this respect accounting in English hospitals is a step behind American practice for although there is considerable lack of uniformity among the American institutions present practice recognizes the desirability of using the organization unit of the hospital as the basis for account classification, with salaries, supplies, and miscellaneous items subordinated to these categories.

Captain Stone presents his material from a wealth of practical experience. He is secretary of the Birmingham Hospital Centre and has been chairman of the commission on hospital finance of the International Hospital Association.—C. RUFUS ROREM.

DIET MANUAL, ST. MARY'S HOSPITAL. Compiled by Sister Mary Victor, R.N., B.S. Rochester, Minn.: St. Mary's Hospital, 1935. Second edition. Pp. 191. \$2.50.

The "Diet Manual" is Sister Mary Victor's compilation of the diet procedures in use at St. Mary's Hospital and the Mayo Clinic.

Part 1, "The Optimum Diet" deals with the daily dietary requirements for the normal adult, standard portions and the standard house diets.

Part 2, "Therapeutic Diets for Adults," is a comprehensive outline of the dietary procedures for various conditions. The section devoted to diabetes has in addition to some standard diabetic diets and menus, diabetic diets for special conditions. A number of useful substitutions and recipes for the diabetic diet is given. The outline for postoperative diets is very complete.

Part 3, "Infant and Child Feeding," gives formulas for infant feeding, requirements for an adequate diet for children, hospital diet lists and therapeutic diets for children. The diets for special conditions are as complete in this section as they are in the section for adults.

Part 4 consists of diet instruction sheets as outlined for the use of the patient.

Part 5, "The Appendix," contains height-weight tables, useful food tables including a table of the oxalic acid content of foods. The Boothby and Berkson Food Nomogram is of sufficient size to be used conveniently.

The manual has been accurately and carefully compiled.—EVELYN ANDERSON.

Hospitals are "Homes"

—where those who suffer may have more tender and more competent care than would be possible in the homes from which they come.

The quality of food you serve should, therefore, be noticeably superior in quality. It should match the other services you render. The effect of serving—



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ENTHUSIASTIC praise from hospital authorities was the greeting of the new Colsonaire—a greeting which is being generously supplemented by purchases.

One and all, the hospital experts who have seen the Colsonaire hail it as an advance in styling and construction—the first real forward step in the wheel chair field in many years.

Steel tubing for the principal supporting members imparts both grace and stability. At the same time, selected woods and woven cane impart a comfortable touch to those portions of the chair which come in contact with the patient. This includes seat, back, leg rests and arm rests.

More durable, sanitary and comfortable, the Colsonaire is ideally maneuverable and quickly adjustable to the patient's needs. It imparts, moreover, a distinction to the institution which adopts it that impresses patients and visitors.

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Tells Ways to Fight Fires

Potentially, we are all fire fighting fans. Such a booklet, then, as "The Modern Dry Method of Fire Extinguishment" just released by Garrison Engineering Corp., Great Barrington, Mass., goes on our "must" reading list. We are informed that Garrison extinguishers No. 20, the portable type, and 100, 100W, 350, and 350W, the wheel type, are approved by Underwriters' Laboratories for use in fires in flammable liquids, greases and the like, where a "blanket" effect is essential, and in electrical equipment fires. Termed new because chemists and engineers have worked over a period of three years perfecting the Garrison appliances, this fire fighting equipment is said to be unusually effective because it uses a dry chemical which gives off quantities of carbon dioxide when heated. The chemical cannot freeze, it is stated, does not deteriorate with age, does not act as a conductor of electricity and will not harm furniture, draperies, clothes, machinery or other objects.

Nurse Rejoices

Aids for nursing technique do materialize now and then. Comes a note from the Jones Metal Products Co., West Lafayette, Ohio, stating that improvements recently made in their male urinal may be slight to casual observers; still, in use the new utensil has advantages acknowledged by nurse and patient alike. Formerly the urinal was made with both ends of the handle welded to the body, and it was awkward to use. With the new type urinal, the handle is welded forward in such a way that the spout turns upward and remains in that position, it is said, preventing spilling and facilitating more comfort in use, specially by patients who can make only slight body movements.

The Sponge That Man Built

At the risk of offending that family of old soaks, the Poriferae, we are constrained to report that man has created a sponge that can absorb more liquid than any one of them. The man-made sponge, just out, is of highly purified wood and cotton cellulose pulp, its spongelike construction being obtained through chemical reactions. Although tough, the new cellulose sponge becomes extremely soft and pliable when wet, and will not scratch the most highly polished surface. Moreover, it is said to outlast the natural product. The creator: Du Pont Cellophane Co., Inc., Cellulose Sponge Div., Empire State Building, New York City.

Collins' Announcements, Four-fold

In full swing at 555 Huntington Avenue, Boston, Warren E. Collins, Inc., sends news of four interesting developments. The one is a Drinker Respirator room reported to be the only one of its kind and specially built for Boston's Children's Hospital. With capacity for four patients in upper and lower berth cots, the room facilitates entrance of doctors and nurses to care directly for patients. Attendants may be conscious of pressure changes but are relieved,

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AIR CONDITIONING
Protects
BABIES' LIVES



IN one well-known hospital, the mortality rate in the premature baby nursery was 28.9%. A ten-year record shows that controlled air conditioning resulted in reducing this to 7%. At the same time, deaths from infection dropped to less than half the former figure.

Many premature and normal new-born baby nurseries are air conditioned by Delco-Frigidaire equipment. Their records show startling results in effectiveness of saving lives, lowering infections, controlling heat rash, and reducing summer diarrhea.

Summer cycle of most importance

While fairly high relative humidities and year-round conditions are maintained by the usual Delco-Frigidaire nursery installation, the most important part of air conditioning in the other departments of hospitals is the summer cycle. This is primarily a cooling and dehumidifying job. The accepted means is electric refrigeration. Delco-Frigidaire, offering the greatest available experience in all phases of electric refrigeration, naturally leads in the design, manufacture, and installation of dependable air conditioning systems.

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it is said, by placing cotton in their ears. A second product is the new tilting and rotating respirator, orthopedic type. Easy tilting for better drainage, simple rotating to prevent hypostatic pneumonia and provision for specific comfort of orthopedic cases are reported benefits. A third item is the open top oxygen tent designed for easy portability around the hospital and into patients' homes. Low original and operating cost, noiselessness and adaptability to patient's position are stated features. A final product is the new VasculeX for suction-pressure therapy. Its newness, as reported, is in its compactness, portability (with casters and handles) and quietness.

Stainlessness Up-to-Date

"It's good for a lifetime, bright for an age" introduces that new Royal stainless flatware—knives, forks and spoons fabricated from Allegheny metal which, as you know, is produced by Allegheny Steel Co., Brackenridge, Pa. Mentioned is the fact that the new tableware is chipless, bendless and dentless in ordinary ware. Other examples of stainless steel fabrication as announced in recent months include a new style autopsy table and a new type dissecting table. Ability to keep dissecting material moist and in good condition without oiled coverings or grease, plus increased sanitation and neat appearance are features reported. According to reports, this metal resists corrosive attacks of chemicals, blood and other body fluids—ease of cleaning and low maintenance cost are among the good results.

Advancing X-Ray Technique

Flashed from Binghamton, N. Y., is news that Agfa Ansco Corporation has developed two new products: a direct duplicating film and a non-screen x-ray film. The first is said to simplify making copies from x-ray and other transparencies. Instead of producing the usual negative image upon exposure and development, this film gives direct duplicates of the original. Thus a single exposure and development produce a duplicate negative from an original negative or a duplicate positive from an original positive. This is reported to cut material cost and working time by half. The second product, the non-screen film, is reported well suited to radiographs of extremities, bone structures and tissue where fine detail is important. This film heightens contrast and is indicated for radiographs of subjects requiring deep penetration where harder x-rays for exposure without loss of contrast are advised for securing the best results.

Sun Lamps on the Move

Patients have always hoped to enjoy their sunning right in their own beds. Now they can, since Sun Lamp builder Hanovia of Newark has begun to produce for bedside and ward work the new Hospital Model Super Alpine unit equipped with handle bar, swivel ball-bearing casters for easy portability. Clearance under the base of the lamp is amply sufficient, it is stated, for movement over door sills. And, knowing that often it's the little things that count, the manufacturer even attaches a tape measure devised to check the distance from lamp to patient. Provision for high intensity, precise dosage control, lessened treatment time, greater number of individual patients treated, low operating cost and adaptability as desired for group treatment—these are a few of the features reported by the manufacturers, Hanovia Chemical & Mfg. Company, Newark, N. J.

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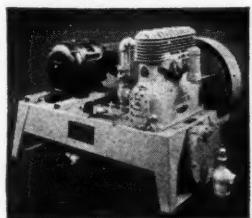
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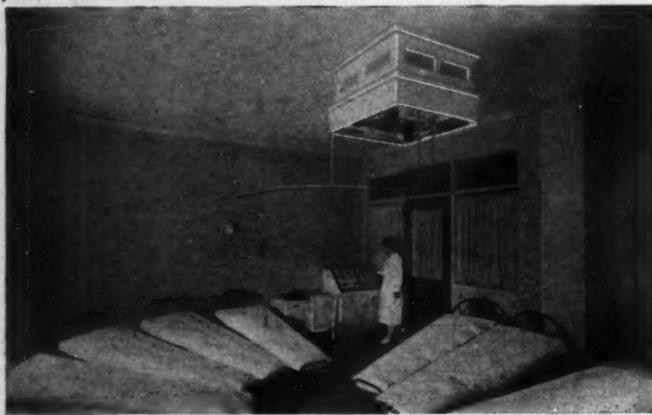
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Trade Literature

Refrigeration in Black and White—Obviously, these columns are a kind of hospitality shop, offering greetings to the best we can find in current literature. Now we salute what seems to us one of the better catalogues, a book with straightforward descriptive and illustrative detail, ungarnished with superlatives. In a new General Electric book, specifications appear (covering such matters as design, construction, capacities, installation, specific application and operation) on refrigerating machines, ice makers, cooling units, conditioned air cooling units, biologic refrigerators, general storage refrigerators, ice cube freezers, and finally on the GE glass and dish washer. This company states that it manufactures refrigeration for every type of hospital application, each requirement engineered according to the needs of the institution. In another illustrated book by General Electric Co., Nela Park, Cleveland, readers are invited to consider electric water coolers which make the drinking water convenient and palatable.

They Sell More Than Paint—Donors of services as well as sellers of paint, U. S. Gutta Percha Paint Co., Providence, R. I., states that a request-on-card will bring an expert to analyze your painting problems. He will survey the hospital and its paint needs and will submit a written report enabling you to paint practically and economically. In the last five years, wall and other surfaces have been, of necessity, neglected. Consequently, special treatments are now required. By the way, "More Light With Lasting Cleanliness" is a booklet offered by this company, whose "Barreled Sunlight" is known everywhere.

Year 'Round Air Treating—Interesting reading for layman and architect alike, is a new book from Delco-Frigidaire Conditioning Corp., Dayton, Ohio, analyzing air conditioning but defining it in readily understood terms. Cooling, dehumidifying, cleaning, ventilating and circulating (functions required in summer) are sketched briefly and understandably, likewise those functions desired in winter (cleaning, ventilating, circulating, heating and humidifying) are clearly outlined. Factors to consider in selecting air conditioning systems, specifications descriptive of Frigidaire equipment and survey analyses available to architects and builders comprise other divisions of the small book. Typical hospital installations are pictured and described, as operating and delivery room, clinic, nursery and nurses' dining rooms. A second book, copyright 1935, entitled "Air Conditioning Application Inventory for Hospital Executives, Physicians and Surgeons," supplies data for hospital folk who want to analyze their own atmospheric problems, whether they are interested in allergy rooms or oxygen therapy chambers.

Re-Introducing "The White Line"—Closely in touch with advancing needs of hospital and surgeon, Scanlan-Morris Company, Madison, Wis., present, in a new 376-page catalogue, the modern in hospital furniture and sterilizing equipment. The first section of the book constitutes a where-to-go department for the newest in operating tables, clinical furniture in general, built-in hospital cabinets and surgical lighting fixtures. Certain pages contain suggested layouts for operating rooms, fracture units, maternity departments or autopsy rooms. Photographed are typical installations of hospital furniture and of surgical lighting. A second section comprises a where-to-look department for purchasers of new sterilizers. Photographs, suggested layouts of equipment, descriptions and diagrams appear in careful portrayal of a wide line of sterilizing apparatus. Warming cabinets are also illustrated.